Community Health Center-800 5thStreet Martin Luther King Jr. Boulevard Lynchburg, Virginia 24504 Phone:(434)200-3366-Fax: (434)200-3106

Notice of Privacy Practices, Release of Information, Consent for Treatment & Financial Guaranty

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.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice applies to all companies located within the Community Health Center (Community Access Network, the Free Clinic, Hill City Pharmacy), including hospital and other inpatient treatment facilities, mobile clinics and screening programs. It applies to all Community Health Center (CHC) employees, staff, other personnel, students, volunteers and anyone authorized to enter information into your medical record. Mental health treatment areas may give patients a supplemental notice describing additional privacy practices. All companies within the CHC may share medical information with each other for treatment, payment, or operational purposes described in this notice.

All of us working at the CHC are committed to protecting the privacy of your medical information. We create and maintain records of the treatment and services that you receive at the CHC in order to provide excellent care. We must also keep records to comply with legal requirements. The law requires us to keep your medical information private, give you this notice of our legal duties and privacy practices, and notify affected individuals following a breach of unsecured protected health information. The law requires us to follow the terms of this Notice. We also have the right to change the terms of this Notice, and these changes will apply to all medical information we maintain. If Community Access Network and the Free Clinic change the terms of this Notice, we will make paper copies of this Notice of Privacy Practices available upon request.

Our Uses & Disclosures

Examples of ways that we use and disclose medical information.

For Treatment:

We may use or share your medical information to provide you with treatment or medical services. For example, we will share medical information about you with healthcare providers, nurses, technicians, therapist, and other people who are taking care of you, including Centra and Horizon Behavioral Health. A variety of individuals and departments who participate in your care but who may not have direct contact with you will need to use your information to coordinate care (e.g., pharmacy supplies, lab and radiology tests, and special dietary requirements). We may contact you to tell you about treatment options, wellness and educational programs, and other health-related benefits or services that may interest you. We may disclose medical information about you to people outside of Community Access Network and the Free Clinic who provide services related to your care, such as home health agencies. We may contact you to remind you of an appointment or a prescription renewal.

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For Payment:

We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or another third party.

For Healthcare Operations:

We may use and disclose information about you for healthcare operations. For example, we may use medical information to review our treatment and services, to perform business planning activities, and to evaluate our staff and the quality of care you receive from us. We may combine information about many patients to evaluate the effectiveness of treatment or operations. We may provide information to members of our workforce for review and educational purposes. We may aggregate information about many patients to compare our performance with other hospitals. We may remove identifying information from what we share for healthcare operations to preserve your anonymity.

Business Associates:

Some services are provided through Community Access Network's and the Free Clinic's business associates. For example, Community Access Network and the Free Clinic may contract with outside companies to provide computer services or transcript and release of medical records functions. We may disclose your medical information to these companies so that they can perform these services for us. Community Access Network and the Free Clinic require business associates to appropriately protect your private information.

Other Providers:

We may disclose medical information to healthcare professionals who have cared or currently are caring for you, such as rescue squads, referring physicians or hospitals, or nursing homes, for their use in your treatment, obtaining payment, or their healthcare operations. This includes Centra Health and Horizon Behavioral Health. Our normal process is to send records of your visit to your referring and/or primary care physician.

Fundraising:

We may contact you to raise funds for Community Access Network and the Free Clinic programs and facilities. We may disclose information to Centra Foundation so that they may contact you for fundraising efforts. We will not disclose or use information about your diagnosis or treatment for this purpose, except that we may use or disclose information about the outcome of your treatment for the screening purposes. You have the right to opt out of receiving these communications.

Health Oversight:

We may share medical information with the United States Department of Health and Human Services if there is an investigation of any entities associated with Community Access Network and the Free Clinic. Community Access Network and the Free Clinic may share your medical information with

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health agencies responsible for oversight activities including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Individuals Involved in your Care or Payment for Care:

We may share medical information with family members, other relatives, or close personal friends if they are involved in your care. Unless you object or you are a behavioral health patient, we may share your general condition or death, as well. We may share your medical information with the public or private organizations to coordinate disaster relief efforts, so your family can be notified about your condition and location.

As Required by Law:

We will disclose medical information about you as required by federal, state, or local law.

Public Health:

We may use or share your medical information for public health activities. Such activities include preventing disease, helping with product recalls, reporting adverse reactions to medications, and reporting suspected abuse, neglect or domestic violence.

Legal Proceedings:

We may share your medical information during legal or administrative proceedings. If you are involved in a lawsuit or a legal dispute, we may disclose your medical information in response to a court administrative order, in response to a subpoena, discover request, or other legal process.

Law Enforcement:

Community Access Network and the Free Clinic may release your medical information for certain law enforcement purposes or other special government functions, such as an in response to a court order, subpoena, warrant, summons, or other legal process. We may also release information about wounds made by certain weapons, criminal conduct at our facilities, or a death we believe may have been related to criminal acts. If you are an inmate of a correctional institution, we may release your medical information to the institution or agents in connection with your health and the health and safety of others.

Medical Examiners and Funeral Directors:

We may disclose your medical information to a coroner, medical examiner or a funeral director.

Organ Donation:

We may share your medical information with an organ or tissue donation and procurement organization.

Research:

We may use or share your medical information for certain research purposes. All research projects are subject to approval by a special board that evaluates proposed research and its use of medical information. In some cases, your information cannot be used for research without your

authorization. In cases where research can be performed using information that has had patient identification removed (such as name and medical record number), we may use or release that data without special approval. All research will include appropriate controls and protocols to ensure your data is protected.

To Avert a Serious Threat to Health or Safety:

We may use or share your medical information to prevent or lessen a serious threat to the health or safety of yourself, another person or the public.

Workers' Compensation:

We may share your medical information as allowed by law for workers' compensation or similar programs.

Military:

If you are a member of the armed forces, we may release information about you as required by military command authorities. We may release medical information about foreign military personnel to the appropriate foreign military authority.

Personal Health Record:

We may place your medical information in an electronic personal health record (PHR). Access to your PHR will be under your control, and you may choose to permit other to see it.

Your Rights Regarding Your Medical Information

Right to Inspect and Copy:

You have the right to inspect or receive a copy of your medical and billing records. You have a right to have a copy sent to another person that you designate. You may request copies of records in an electronic format. If the records are available in electronic format, we will accommodate that request. Otherwise we will provide an alternative format. You have a right to obtain copies for a reasonable fee. Contact our records department for more information. We may deny your request to inspect and copy our records under very limited circumstances, and you may request a review of our denial. Another healthcare professional chosen by Community Access Network and the Free Clinic will conduct the review of our denial.

Right to Amend:

You have the right to ask to amend your medical information if you believe our records are inaccurate or incomplete. You have the right to request an amendment for as long as the information is kept by or for our organization. You must make the request in writing and include a reason for the request. Community Access Network and the Free Clinic may deny your request. For example, we may deny a request to amend information that we did not create, or that is accurate and complete. If denied, we will provide you with written reason for the denial.

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Right to Receive Notice of Privacy Breach:

Community Access Network and the Free Clinic will notify you in writing if there has been a breach of your identifiable health information.

Rights to Request Restrictions:

You have the right to restrict disclosure of your health information to your health plan for services paid out of pocket in full prior to the service being provided. This restriction applies if the disclosure to the health plan is for purposes of payment of healthcare operations and the health information relates to a healthcare item or service for which we have been paid in full prior to the service.

You have the right to request other restrictions or limits in how we disclose your medical information for treatment, payment, or operations purposes, or disclosure of your health information to someone who is involved in your care or payment for your care. Community Access Network and the Free Clinic are not required to agree to your request. For example, we will not be able to meet a request that would interfere with your treatment, such as restricting which members of our workforce may have access to your records or limiting access by your primary care or referring physicians.

Rights to Request Alternative Communication:

You have the right to request that we communicate with you about medical matters in a particular manner or at a certain location. For example, you may ask that we contact you at home rather than at work. Community Access Network and the Free Clinic will accommodate all reasonable requests that are within our technical capabilities. You must make requests for alternative communication in writing.

Rights to Accounting of Disclosure:

You have the right to ask for an Accounting of Disclosures. This is a list of times we shared your information for reasons other than treatment, payment, healthcare operations, of which you were not previously aware. The first list you request in a 12-month period will be free. For additional lists within the same 12-month period, we may charge you for the costs of providing the list. You must submit your request in writing.

Rights to a Paper Copy of This Notice:

You have the right to ask for a printed copy of this Notice of Privacy Practices.

Rights to Complain:

You have the right to file a complaint with Community Access Network, the Free Clinic and/or Secretary of the United States Department of Health and Human Services if you believe we have violated your privacy rights. To complain to Community Access Network and the Free Clinic, contact our Privacy Officer, Emma Cetina at (434) 200-3366 ext. 3877. You will not be penalized for filing a complaint.

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Other Uses of Medical Information

Community Access Network and The Free Clinic will not disclose your medical information for any other purpose without your written permission. Once you give us permission, you can revoke that permission in writing at any time. If you do so, we will not be able to take back any disclosures that have been made with your permission.

PATIENT CHOICE

Community Access Network and the Free Clinic partner with Centra Health, Horizon Behavioral Health and other community providers to offer a range of services for patients, most at no cost for the patient. I understand that I am not obligated to accept referrals from Community Access Network or Free Clinic to these providers, and may request referrals to providers of my choice. I acknowledge, however, that other providers may have differing charity care policies and that I may be required to pay for these services.

TELEMEDICINE

Providers with Community Access Network and the Free Clinic provide telemedicine services from locations within the Commonwealth of Virginia and therefore are bound by the laws of Virginia. Electronic systems used incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Benefits to telemedicine include: improved access to medical care by enabling a patient to remain in his/her location while the provider is in another location, more efficient medical evaluation and management, and obtaining expertise of a distant specialist.

Possible Risks:

As with any healthcare service, there are potential risks associated with telemedicine. These risks include, but are not limited to: In rare instances, information transmitted may not be sufficient to allow for appropriate decision-making by the provider. Delays in evaluations and treatment could occur due to deficiencies or failures of the electronic equipment. In rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

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MOTOR VEHICLE ACCIDENT

If This Visit Related to a Motor Vehicle Accident (MVA):

I understand that my signing this form indicates that my motor vehicle insurer will pay directly to the health care provider, from any medical expense benefits available to me under any motor vehicle insurance policy, any copayments, coinsurance, or deductibles owed by me (the injured covered person) to the health care provider if I (the covered injured person) am covered under a health care policy, the health care provider is an in-network provider, and the health care provider has submitted claims to the health insurer for health care services. If I (the injured person) is not covered under a health care policy or the health care provider is not an in-network provider, the motor vehicle insurer shall pay directly to the health care provider, from such available benefits, amounts to cover the cost of the health care services rendered. A motor vehicle insurer shall be held harmless for making payments to health care provider pursuant to valid assignment of benefits.

CONSENTS

Release of Information to Insurance Companies:

I authorize Community Access Network and the Free Clinic of Central Virginia to release any part of the patient's medical record to insurance companies or other third-party payors, as needed to verify insurance coverage, submitted claims, or pay claims. (The Information to be released may include psychiatric or mental health records, drug and alcohol abuse conditions, or information about HIV status and AIDS.)

I hereby voluntarily consent to my admission to and/or treatment by Community Access Network and the Free Clinic of Central Virginia and to the rendering of such care and medical treatment as may be deemed necessary by my medical provider or by any employee or agent of Community Access Network and The Free Clinic, or others associated with a medical education, training or emergency medical services program, who may carry out part or all of my treatment under the direct supervision of my medical provider. Community Access Network and the Free Clinic services and care to be provided may include x-ray examination, laboratory procedures (including drug screens), anesthesia, diagnostic procedures and other medical or surgical treatment as my medical provider may consider necessary. I hereby authorize my medical provider to permit the presence of such observers, including, but not limited to, medical residents, medical students and others associated with a medical education and/or health care training or EMS program, and healthcare industry representatives, as my medical provider may deem appropriate while I am undergoing treatment.

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Telemedicine:

I hereby consent to engaging in telemedicine with providers at Community Access Network and the Free Clinic of Central Virginia. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

By Signing this Form, I Understand the Following and consent to the use of telemedicine in my care.

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that the laws that protect the privacy and security of health information apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my authorization.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time.
4. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
6. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that if my medical insurance coverage (except for government health programs) is not sufficient to satisfy the medical service charges in full, I will be fully responsible for payment.

I have read and understand the information provided above regarding telemedicine, have discussed it with staff, and all of my questions have been answered to my satisfaction.

Virginia Prescription Monitoring Program:

I acknowledge that Community Access Network and the Free Clinic may access information contained in the Virginia Prescription Monitoring Program files on all Schedule II, III, or IV prescriptions dispensed to me. Clinicians may also communicate with pharmacies regarding my prescriptions.

Notice of Deemed Consent for HIV, Hepatitis B and Hepatitis C blood testing:

I understand that Virginia Code 32.1-45.1 authorizes healthcare providers to test patients for HIV antibodies, Hepatitis B and Hepatitis C when the healthcare providers or any person employed by or under the direction and control of the healthcare provider is exposed to the body fluids of a patient in a manner which may be transmit blood borne diseases, human immunodeficiency virus (HIV) and Hepatitis B or C. Pursuant to this law, in the event of such exposure, I will have deemed to have consented to such testing, and to have consented to the release of the test results to the healthcare provider who may have been exposed. Positive test results will also be disclosed as medically necessary for my treatment or as a required or permitted by law.

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Medicare:

If I am covered by Medicare, I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Community Access Network and the Free Clinic. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Insurance Payments:

I authorize my insurance company to pay for services provided to the patient that were rendered at Community Access Network and the Free Clinic. I understand that I am financially responsible to Community Access Network and the Free Clinic for the charges not covered by insurance or other third-party payors. I agree that the assignment of benefits and release of information includes all professional services rendered to me by any medical provider and/or a member of the medical staff of Community Access Network and the Free Clinic for the purpose of filling my claims.

Pre-Certification:

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment, and I will be responsible for all balances.

I acknowledge that I have been given Community Access Network and the Free Clinic Notice of Privacy Practices. I agree that a photocopy of this form will be valid as the original to the third-party payor(s) in processing or payment of a claim for these services. In this form, "I" Includes all individuals who sign this form. All individuals who sign this form agree that they are individually responsible for the charges not covered by insurance or other third-party payors.

Guaranty of Account:

I agree to pay all charges of Community Access Network, the Free Clinic, medical providers and/or a member of the medical staff for services provided to the patient. No extensions that may be granted to the patient and no delays by Community Access Network and the Free Clinic or members of its medical staff in enforcing any rights against the patient will release me or affect my financial liability. My obligation to pay is cumulative and in addition to all other remedies of Community Access Network, the Free Clinic, medical providers and staff from a Consumer Reporting Agency as regulated by the Fair Credit Reporting Act and expressly authorize the use of automatic dialing system and pre-recorded voice form contact by telephone, cellular telephone, paging services or electronic mail. The undersigned acknowledges that they have been provided information on Community Access Network and the Free Clinic financial and payment policies.

Missed Appointments:

I understand repeated cancellation of appointments or missed appointments are subject to missed appointments fess ($5 for primary care / $10 for specialty care) and/or practice dismissal in accordance with state regulations.

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Conditions of Acceptance for the VCU/HU School of Dentistry:

The Free Clinic hosts the student teaching program of the Virginia Commonwealth University School of Dentistry (VCU), as well as the Howard University School of Dentistry (HU). As a dental patient at the Free Clinic, you may be provided care by students or residents under the supervision of a licensed dentist. By signing this form, you agree to participate as a patient in this program, which includes screening exam and, if eligibly subsequent treatment.

I understand that the purpose of the screening exam is to determine whether I can be accepted for care in the student teaching program of the VCU and/or HU School of Dentistry. I understand that acceptance is based upon the educations objectives and needs if the academic program. If accepted, I agree to notify the dental clinic the day before the appointment (24) hours if I must cancel that appointment. I also understand that repeated cancelation or excessive tardiness may be cause for dismissal from the Dental program.

I understand and agree that my records and the records pertinent to my treatment are the property of the VCU and/or HU School of Dentistry; however, upon written request, the dental school will provide me with copies of my record.

I hereby give consent to be photographed, filmed or videotaped in connection with the treatment, education and research program of the VCU and/or HU School of Dentistry. I understand and agree that all such photographs, films and tapes are the property of the VCU and/or HU School of Dentistry.

I understand and agree that for the purposes of the VCU and/or HU School of Dentistry's Quality Assurance Program staff charged with the oversight of quality assurance activities will review my records to ensure that standards of care have been met.

I further understand and agree that the VCU and/or HU School of Dentistry and its faculty shall be permitted to use all or part of my patient record, either in photographic form or in scientific writing, for publication or scientific journals, or for the advancement of dental education. All personal information will be protected to prevent identification of the patient either directly or indirectly.

MORE INFORMATION

THIS NOTICE IS EFFECTIVE April 13, 2020

For more information, contact Community Access Network and the Free Clinic at (434) 200-3366 or write to us at 800 5th Street, Lynchburg, VA 24504.

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I have received a copy of Community Access Network and the Free Clinic of Central Virginia Notice of Privacy Practices. I understand that Community Access Network and the Free Clinic of Central Virginia have the right to change this Notice of Privacy Practices from time to time and that I may contact Community Access Network and the Free Clinic at any time to obtain a current copy of the Notice of Privacy Practices.

I have verbally notified the Community Access Network and Free Clinic of Central Virginia of my personal contacts who are permitted to access my medical information.

I have read and understand the information provided above regarding consents to treatment and other consents, and all of my questions have been answered to my satisfaction.

To be signed by patient or legal guardian if patient is a minor under the age of 18, or legally unable to give informed consent.

Patient/Legal Representative Signature: _____

Legal Representative Printed Name: _____

Date: _____