



School Based Telehealth
Coordinated Care Program
623 North 9th Street, Ste 500
Augusta, AR 72006
(870)347-3461 (P) (870)347-1615 (F)

Dear parent/guardian:

We are excited to have the opportunity to work with your child's school to provide acute care during the school day throughout the 2019/2020 school year. Please complete the attached ARcare packet to ensure we are providing your child the highest quality medical care. Please return the packet to your child's school nurse at your earliest convenience. Please contact the school or our office with any questions you may have.

Respectfully,

ARcare | Coordinated Care Program
623 North 9th Street, Ste 500, Augusta, AR 72006



School Based Telemedicine: What to Expect

Providers at ARcare clinic sites are working in partnership with the nurse within your school district to offer you telemedicine services.

What is Telemedicine?

Telemedicine is the exchange of medical information from one site to another via electronic communications. The telemedicine service offered to you will allow you to have a medical appointment with a specialist via secure and interactive video equipment. You will be able to speak in real-time with the specialist during your telemedicine appointment.

Is Telemedicine Safe?

Yes, all telemedicine sessions are safe, secure, encrypted, and follow the same privacy (i.e., HIPAA) guidelines as traditional, in-person medical appointments. Your telemedicine appointments will always be kept confidential. In addition, telemedicine appointments are NEVER audio or video recorded.

Can I Choose Not to Participate?

Of course, with this program you have been offered the option of seeing an ARcare provider via secure and interactive video equipment within your school. It is your choice to use these services.

Things to Remember about Your Telemedicine Appointment:

1. You will initiate your telemedicine visit by letting your school nurse know that you have an acute illness or injury.
2. The school nurse will triage you prior to beginning the telemedicine visit.
3. If you have any questions before or after the session, you may ask your school nurse or contact the ARcare Coordinated Care office at 870-347-3461.
4. The *Telemedicine New Patient Packet* must be completed prior to initiating your first Telemedicine session. You must complete these forms in order to begin your Telemedicine appointment:
 - *Telemedicine Consent Form*
 - Any other forms/consents the spoke/patient or hub/specialist site or legal team require, including the *Notice of Privacy Practices, Patient Rights and Responsibilities Form and the HIE Consent to View Form.*
5. If you are prescribed medication(s) by the ARcare provider you will be able to pick it up directly at your pharmacy of choice as the ARcare provider will either phone in or electronically prescribe your medication(s).
6. If you need a prescription refill or you have any questions about your medication, you must call ARcare directly at 870-347-3461. The Coordinated Care staff will contact your ARcare provider. Please be sure to call at least 72 hours prior to running out of medication.

**If you have any questions or concerns after reading this form please contact
Coordinated Care team at 870-347-3461.**



**School Based
Telemedicine Consent Form**

1. I authorize _____ School to allow me/the patient to participate in a telemedicine (videoconferencing) service with ARcare.
2. The type of service to be provided via telemedicine is Acute Care Services.
3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by the clinical staff at my/the patient's location under the direction of the telemedicine healthcare provider.
4. My/the patient's physician has fully explained to me the nature and purpose of the videoconferencing technology and has also informed me of expected risks, benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The attendant risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telemedicine service if we believe that the videoconferencing connections are not adequate for the situation.
6. I understand that the telemedicine session will not be audio or video recorded at any time.
7. I agree to permit my/the patient's healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telemedicine service to operate the video equipment. I further understand that I will be informed of their presence during the telemedicine services. I acknowledge that if safety concerns mandate additional persons to be present, then my/guardian permission may not be needed.
8. I acknowledge that I have the right to request the following:
 - a. Omission of specific details of my/the patient's medical history/physical examination that are personally sensitive, or
 - b. Termination of the service at any time.
9. When the telemedicine service is being used during an emergency, I understand that it is the responsibility of the telemedicine provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.
10. It is the responsibility of the telemedicine provider to conclude the service upon termination of the videoconference connection.
11. I/the patient understand(s) that my/the patient's insurance will be billed by both the local healthcare provider and the telemedicine healthcare provider for telemedicine services. I/the patient understand(s) that if my insurance does not cover telemedicine services I/the patient will be billed directly by the telemedicine healthcare provider for the provision of telemedicine services.
12. My/the patient's consent to participate in this telemedicine service for the duration of the specific service identified above, or until I revoke my consent in writing.

13. I/the patient agree that there have been no guarantees or assurances made about the results of this service.
14. I confirm that I have read and fully understand both the above and the *Telemedicine: What to Expect Form* provided. All blank spaces have been completed prior to my signing.

Patient Name

Patient Date of Birth

Patient/Relative/Guardian Signature*

Print Name

Relationship to Patient (if required)

Date

Interpreter (if required)

Date

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Telemedicine School Nurse Facilitator

Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD



Patient Demographic Form

PATIENT INFORMATION

Date of Birth _____ **Social Security Number** _____ **Sex** Male Female

Gender (Circle One)
Female Male Refused to Report
Genderqueer (Neither exclusively male nor female) Other, please specify: _____
Male to Female/Transgender Female/Trans Woman Female to Male/Transgender Male/ Trans Man

Marital Status (Circle One)
Married Single Divorced Life Partner Separated Widowed Other

Language if other than English:

Race (Circle One) Black-Non Hispanic American Indian/Alaskan Native Hispanic
Asian/Pacific Islander White- Non Hispanic Other

Ethnicity (Circle One) Not Hispanic/Latino Another Hispanic, Latino/a, or Spanish Origin Cuban
Puerto Rican Mexican, Mexican American Chicano/a Unreported/Refused to Report

Housing Status (Circle One) Doubling Up Homeless Shelter Not Homeless Other
Public Housing Street Transitional Unknown

Home Address _____ **Apt #** _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address _____

Employment Status (Circle One) Disabled Full-Time Part-Time None
Retired Student Unemployed Veteran Migrant or Seasonal Worker

ADDITIONAL INFORMATION

Have you recently been to the hospital for the same reason you are here today? Yes No
If yes, where and when?

Would you like text message appointment reminders? Yes No
Cell Phone Carrier _____



PHARMACY INFORMATION

Pharmacy Name City State Zip Code

GUARANTOR INFORMATION

Relationship to Patient Self (If self, skip to Emergency Contact) Spouse Parent Other

Last Name First Name Middle Initial

Date of Birth Social Security Number

Home Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

Employment Status (Circle One) Disabled Full-Time Part-Time None Retired
Student Unemployed Veteran Migrant or Seasonal Worker

CAREGIVER INFORMATION

Relationship to Patient Self (If self, skip to Insurance Information) Spouse Parent Other

Last Name First Name Phone Number

INSURANCE INFORMATION

Insured Yes No Insurance Name Policy Number Group Number

Policyholder's Name (First/Last) Policyholder's Date of Birth

Relationship to Patient Self Spouse Parent Other Policyholder's Employer

Insurance Company Address Phone Number

Secondary Insurance Name Policy Number Group Number

Policyholder's Name (First/Last) Policyholder's Date of Birth

Relationship to Patient Self Spouse Parent Other Policyholder's Employer

Insurance Company Address Phone Number

Staff Use Only

Updated/Verified: _____ Date: _____



Patient Medical History

Patient's Name and Date of Birth: _____

PCP Name, Number, and Address: _____

List all your child's current prescribed or non-prescribed medications (Dosage and frequency):

Any allergies? Yes No If yes, please list all allergies and reactions.

List any Surgeries: _____

Please check if the child has had any of the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Behavioral Disorders |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bleeding problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Development disorders |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Depression/Anxiety | |

Other, please specify: _____

Family Medical History

Age

Diseases (If none, write the N/A)

If deceased, cause of death

Father: _____

Mother: _____

Siblings: _____



CONSENT TO TREATMENT

I give permission for ARcare/KentuckyCare/MississippiCare to give _____
medical treatment. Patient's Name

Date of Birth: _____ SSN: _____

Initial ONE:

- I am the patient.
- Patient is a minor who is _____ years of age.
- Patient is an adult who cannot act on his or her own.

If Patient is a minor:

I give permission for my child to receive an examination and treatment in the absence of adult supervision.

- Yes No

I give permission for the following individuals (other than parent/legal guardian) to bring my child to the clinic on my behalf (**Select at least ONE**):

- None School staff Clinic staff Daycare staff Other (*please list*)

Emergency Contact	Relationship	Phone Number

1. I voluntarily consent to medical care recommended by the medical provider including, x-rays, heart tracings, medications, and/or routine laboratory testing (including human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if ordered by a clinician for diagnostic purposes).
2. I authorize the clinic to release medical information to insurance carriers for the purposes of filing insurance claims related to my/his/her medical care.
3. I agree that insurance (if applicable) will billed for services and I (patient, parent or guardian of the patient) am responsible for any charges not paid or denied by the insurance company.
4. I understand that even if you have a copy of my Advance Directive or Living Will that clinic staff will attempt to stabilize me and transfer me to an acute care hospital for further evaluation and treatment.
5. This form has been fully explained to me and I understand its contents.

COMMENTS: _____

Signature of patient or adult consenting for patient Relationship to Patient Date

Signature of staff who explained the contents of this consent form Date



PATIENT FINANCIAL OBLIGATION FORM

I UNDERSTAND THE FOLLOWING:

- I am responsible for any charges that are incurred during my office visit.
- If I have insurance, I am responsible for co-pays, deductibles and co-insurance.
- If I fail to meet my financial obligations, my account will be sent to a collection agency after 90 days.
- I will have an opportunity to pay on this account before it will be sent to collections.
- I will receive 3 statements before my account will be turned over to collections.
- If I overpay and have a credit, the credit will be applied to other open claim balances. If no open claim balance exists and I have been turned over to a collection agency in the past, an in-house credit will be provided and issuance of a refund check will be deferred for one year.
- A payment plan is available at my request for unpaid balances before going to collections.
- Should I be unable to make a payment on my account at this time, I understand that the clinic will see me regardless of my ability to pay.

The organization's discounted fee program has been explained to me.

I do [] OR do not [] wish to participate in this program.

DISCLAIMER

I understand, acknowledge, and agree that to collect any money that I owe to the facility:

- I may be contacted by telephone or text message to any phone number that I give or is included on my account (including cell phone numbers that can result in charges on my phone account).
- ARcare/KentuckyCare/MississippiCare, or any other collection or servicing agency operating on behalf of the organization may contact me with auto dialing devices, pre-recorded messages, or voice mail messages.
- ARcare/KentuckyCare/MississippiCare, or any other collection or servicing agency operating on behalf of the organization may contact me using any e-mail address I provide to the organization or that is included on my account.

I understand the collection policy as explained above.

Patient OR Guarantor Signature

Date

Print Patient Name

Date of Birth

Patient OR Guarantor Mailing Address: _____

Staff Witness Signature

Date



HOUSEHOLD ASSESSMENT

(ONLY for patients requesting discounted services)

ARcare/ KentuckyCare /MississippiCare offer a discounted fee program (nominal/sliding fee discount) to eligible patients who apply for assistance. The discounts are based on the Federal Poverty Guidelines. Discounts are given up to 200% of the Federal Poverty Level. Income verification must be provided **before discounts will be applied**. Discounts will not be given to households above 200% of the Federal Poverty Level.

Is Patient head of Household? [] yes [] no

If no, who is the head of Household? _____

List all dependents (anyone who resides with you and for whom you have legal, custodial, or financial responsibility. Please list the **total monthly** gross income for each household member.

<i>Name</i>	<i>Relation to Patient</i>	<i>Birth Date</i>	<i>Income</i>
	<i>self</i>		

By signing this application, I represent that the information and answers given in this application are true, complete and correctly recorded. If fraudulent misstatements were made, the organization reserves the right to request full payment for services provided to the patient. I understand that any charges for my household that are not covered by the discounted service program are my responsibility for my household and I agree to pay for these charges

Signature

Date

For office use only: Show your calculations

Total Annual Income: _____ Total of Household Members Qualified: _____

Eligible for Sliding Fee Discount Program Level: (Circle one)

MEDICAL: [A -\$30] [B - 20%] [C - 40%] [D - 60%] [E - 80%] [F- 95%] [G - 100%]

DENTAL: [A -\$60] [B -40%] [C -30%] [D -20%] [E - 10%] [F- 5%] [G- 100%]

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

Reviewed by: _____

Date: _____



HIPAA PRIVACY PRACTICES CONSENT FORM

We are committed to providing security for patient privacy and confidentiality. We collect, use, and disclose personal health information only when allowed by state and federal laws and your personal authorization. This may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

We also understand you may have family members or significant people in your life who you may want to have access to certain information contained in your medical record. Without your written consent, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act. **Please note that we use an automated phone system to remind you of appointments as well as offer patients the opportunity to complete a survey about their visit.**

I give permission for those (employees, students, volunteers, contractors, etc.) acting on behalf of the organization to share my protected health information (PHI) with the following specific person(s): ***(If no other person is authorized to receive your PHI, write N/A in the spaces below.)***

<i>Name of Individual to which information can be released</i>	<i>Information to be released (Enter corresponding # from list)</i>

Information to be released:

- [1] Copy of complete health record
- [2] History and physical
- [3] Test results
- [4] Mental health records
- [5] Reproductive health records
- [6] Other _____

If 12-17 years of age, patient must sign here to acknowledge approval of information to be released.

*****I understand that I can revoke this release of medical information at any time by completing a new form.***

I give my permission to: ***(INITIAL all that apply) MUST INITIAL AT LEAST ONE***

- [] Leave a message on my answering machine or other electronic device(s) about my appointments, lab results, follow-up care, or other medical information
- [] Contact me at my home address and phone number.
- [] Leave a message with the person indicated as a "message" number if I cannot be reached otherwise.
- [] Send me an email message at: _____.
- [] Contact me regarding voluntary participation in a clinical research. I understand that by checking this box I am NOT obligated to participate in any specific project. Please contact me about projects by:
 - [] mail [] phone [] email address:
- [] I have received a copy of the Notice of Privacy Practices.

Print Name of PATIENT

Date of Birth

Signature of Patient OR Guardian

Date



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 GET 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 as protected by law, including the Health Information Portability and Accountability Act (HIPAA). 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 information that identifies you. We also are 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 Personally Identifiable Information (PII). 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 PII
- Your privacy rights in your PII
- Our obligations concerning the use and disclosure of your PII

This notice describes ARcare's/KentuckyCare's/MississippiCare's privacy practices and that of:

- All of our doctors, nurses, and other health care professionals authorized to enter information about you into medical chart.
- All of our departments including medical records, billing and insurance departments.
- All of our employees, staff, volunteers and other personnel who work for us or on our behalf.
- In addition these sites and locations may share medical information with each other for treatment, payment or operation purposes described in this notice.

The terms of this notice apply to all records containing your PII 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 doe 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 offices 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 ANY QUESTIONS ABOUT THIS NOTICE:

Privacy Officer
P.O. Box 497, Augusta, AR 72006
Phone: (870)347-3474

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PII) IN THE FOLLOWING WAYS:

- 1. Treatment.** Our practice may use your PII 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 PII in order to write a prescription for you, or we might disclose your PII 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 PII in order to treat you or to assist others in your treatment. Additionally, we may disclose your PII to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PII to other health care provides for purpose related to your treatment.
- 2. Payment.** Our practice may use and disclose your PII in order to bill and collect payments for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits

(and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PII to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PII to bill you directly for services and items. We may disclose your PII to other health care providers and entities to assist in their billing and collection efforts. You have the right to restrict disclosures of protected health information to health plans if you have paid for services out of pocket in full.

3. **Health Care Operations.** Our practice may use and disclose your PII 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 PII to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PII to other health care providers and entities to assist in their health care operations. We may make your health information available electronically through an electronic health information exchange to other health care providers and healthcare plans that request your information for their treatment and payment purposes. Participation in electronic health information exchange also lets us see their information about you for our treatment and payment purposes.
4. **Appointment Reminders.** Our practice may use and disclose your PII to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your PII to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your PII to inform you of health-related benefits or services that may be of interest to you.
7. **Fundraising.** We may contact you to raise funds for our organization.
8. **Release of Information to Family/ Friends.** Our practice may release your PII to a friend or family member that is involved in your care or assists in taking care of you. For example, a parent or guardian may ask a babysitter to 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.
9. **Disclose Required by Law.** Our practice will use and disclose your PII when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR PII IN CERTAIN SPECIAL CIRCUMSTANCES

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

1. **Public Health Risks.** Our practice may disclose your PII 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 about 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 agencies and authorities 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 PII 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 PII in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PII in response to a discover 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 had requested.
4. **Law Enforcement.** We may release PII if asked to do so by 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 had 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 PII to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their job.
 6. **Organ and Tissue Donation.** Our practice may release your PII to organizations or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order or tissue donation and transplantation if you are an organ donor.
 7. **Research.** Our practice may use and disclose your PII for research purpose in certain limited circumstances. We will obtain your written authorization to use your PII for research purpose except when Internal or Review Board of Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) and adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurance that the PII will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the reach study, or for other research for which the use of discloser would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PII.
 8. **Serious Threats to Health or Safety.** Our practice may use and disclose your PII 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 PII 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 PII to federal officials for intelligence and national security activities authorized by law. We also may disclose your PII to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations..
 11. **Workers' Compensation.** Our practice may release your PII for workers' compensation and similar programs.
 12. **Coroner, Medical Examiner, Funeral Director.** We may release Health 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 also may release Health Information to funeral directors as necessary for their duties.
 13. **Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
 14. **Inmates or Individuals in Custody..** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) the safety and security of the correctional institution.

E. YOUR RIGHTS REGARDING YOUR PII

You have the following rights regarding the PII that we maintain about you:

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 request. 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 PII for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PII to other 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 PII, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- a) the information you wish restricted;
 - b) whether you are requesting to limit our practice's use, disclosure or both; and
 - c) to whom you want the limits to apply
- 3. Inspection and copies.** You have the right to inspect and obtain a copy (paper or electronic) of the PII 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 in order to inspect and/or obtain a copy of your PII. 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 will conduct reviews.
- 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. You must provide us with a reason that supports your request for amendment. 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 PII kept by or for the practice; (c) not part of the PII which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information 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 not-routine disclosures our practice has made of your PII for non-treatment, not payment or non-operations purpose. Use of your PII as part of the routine patient care in our practice is not required to be documented. For example, the doctor was sharing information with nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. To obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an accounting of disclosure must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month periods is free of charge; but our practice may charge you for additional lists within the same 12-month periods. Our practice will notify you of the costs involved with addition requests, and you may withdraw your request before you incur any costs.
- 6. Rights 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.
- 7. 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 without practice, contact the Privacy Officer.

Privacy Officer
P.O. Box 497, Augusta, AR 72006
Phone: (870)347-3474

We urge you to file your complaint with us first and give us the opportunity to address your concerns. 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/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 PII may be revoked at any time in writing. After you revoke you authorization, we will no longer use or disclose your PII for the reasons described in the authorization. Please note, we are required to retain records of you care.
- 9. Right to Notice in the Event of a Breach.** Our practice will notify you in the event there is a breach of your PII.

For complete details about how we may use your PII, please visit:

<https://www.arcare.net/PrivacyPolicy>
<https://www.kentuckycare.net/PrivacyPolicy>
<https://www.mississippicare.net/PrivacyPolicy>