PATIENT AGREEMENT
ALERE FAMILY HEALTH, LLC

This is an Agreement entered into on _____, 20____, between Alere Family Health, a Pennsylvania Limited Liability Company (Clinic, Us or We), and _____ (Patient or You).

Background

The CLINIC is a Direct Pay primary care practice (DPC), which delivers primary care services through its physicians, Drs. Chris Lupold and Susan Mellinger (Physicians), at 334 Hartman Bridge Rd, Ronks, PA 17572. In exchange for certain fees, the CLINIC, agrees to provide You with the Services described in this Agreement on the terms and conditions contained in this Agreement.

Definitions

1. **Patient**. In this Agreement, "Patient" means the persons for whom the Physician shall provide care, and who have signed this agreement or are listed on the document attached as Appendix B, which is a part of this agreement.

2. **Services**. In this Agreement, "Services", means the collection of services, offered to you by Us in this Agreement. These Services are listed in Appendix A(1), which is attached and a part of this Agreement.

Agreement

3. **Term**. This Agreement will commence on the date signed by the parties below and shall continue for a period of one month.

4. **Renewal**. The Agreement will automatically renew each month unless either party cancels the Agreement by giving 30 days written cancellation notice.

5. **Termination**. Regardless of anything written above, You always have the right to cancel this agreement. Either party can end this agreement at any time by giving the other party 30 days written notice.

6. **Payments and Refunds – Amount and Methods**. In exchange for the Services (see Appendix A(1)), You agree to pay Us a monthly fee in the amount that appears in Appendix C, which is attached and is part of this Agreement.

a) This monthly fee is due no later than the 25th day of each month.

b) The Parties agree that the required method of monthly payment shall be by automatic payment through a debit or credit card, or bank draft.

c) These fees may change with time. You will be notified at least 30 days in advance of any fee changes.

d) If this Agreement is cancelled by either party before the Agreement ends, We will review and settle your account as follows:

(i) We will refund to You the unused portion of your fees on a per diem basis; or

(ii) If the Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees, You shall reimburse the CLINIC in an amount equal to the difference between the value of the services received and the amount You paid in membership fees over the term of the Agreement. The Parties agree that the value of the services is equal to the CLINIC's usual and customary fee-for-service charges. A copy of these fees is available on request.

7. **Non-Participation in Insurance**. Your initials on this clause of the Agreement acknowledges the Patient's understanding that neither the CLINIC, nor its Physician, participate in any health insurance or HMO plans or panels and have opted out of Medicare. Neither make any representations that the fees paid under this Agreement are covered by the Patient's health insurance or other third party payment plans. It is the Patient's responsibility to determine whether reimbursement is available from a private, non-governmental insurance plan or HSA and to submit any required billing.

8. **Medicare**. This agreement acknowledges the Patient's understanding that the Physician has opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for the Patient by the Physician. The Patient agrees not to bill Medicare or attempt to obtain Medicare reimbursement for any such services. If the Patient is eligible for Medicare, or becomes eligible during the term of this Agreement, then s/he will sign the Medicare Opt Out and Waiver Agreement attached as Appendix D and incorporated by reference. The Patient shall sign and renew the Medicare Opt Out and Waiver Agreement every two years, as required by law.

9. **This Is Not Health Insurance**. Your initials on this clause of the Agreement acknowledges Your understanding that this Agreement is not an insurance plan or a substitute for health insurance. The Patient understands that this Agreement does not replace any existing or future health insurance or health plan coverage that Patient may carry. The Agreement does not include hospital services, or any services not personally provided by the CLINIC, or its employees. The Patient acknowledges that the CLINIC has advised the Patient to obtain or keep in full force, health insurance that will cover the Patient for healthcare not personally delivered by the CLINIC, and for hospitalizations and catastrophic events.

10. **Communications**. The Patient acknowledges that although Clinic shall comply with HIPAA privacy requirements, communications with the Physician using e-mail, facsimile, video chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, **Patient expressly waives the Physician's obligation to guarantee confidentiality with respect to the**

above means of communication. Patient further acknowledges that all such communications may become a part of the medical record.

By providing an e-mail address and cell phone number on the attached Appendix B, the Patient authorizes the CLINIC, and its Physicians to communicate with him/her by email or text message regarding the Patient's "protected health information" (PHI).[1] The Patient further acknowledges that:

(a) E-mail and text message are not necessarily secure mediums for sending or receiving PHI, and there is always a possibility that a third party may gain access;

(b) Although the Physician will make all reasonable efforts to keep e-mail and text communications confidential and secure, neither the CLINIC, nor the Physician can assure or guarantee the absolute confidentiality of these communications;

(c) At the discretion of the Physician, e-mail and/or text communications may be made a part of Patient's permanent medical record; and

(d) You understand and agree that e-mail and text messaging are not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. **In an emergency, or a situation that You could reasonably expect to develop into an emergency, you understand and agree to call 911 or go to the nearest Emergency room, and follow the directions of emergency personnel.**

(e) Email/Text Messaging Usage. **If You do not receive a response to an email or text message within 1 business day, you agree that you will contact the Physician by telephone or other means.**

(f) Technical Failure. Neither the CLINIC, nor the Physician will be liable for any loss, injury, or expense arising from a delay in responding to Patient, when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service provider; (ii) power outages; (iii) failure of electronic messaging software, or e-mail provider; (iv) failure of the CLINIC's computers or computer network, or faulty telephone or cable data transmission; (iv) any interception of e-mail communications by a third party which is unauthorized by the CLINIC; or (v) Patient's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

11. **Physician Absence**. From time to time, due to vacations, illness, or personal emergency, the Physician may be temporarily unavailable to provide the services referred to in this agreement. In order to assist Patients in scheduling non-urgent visits, CLINIC will notify Patients of any planned Physician absences as soon as the dates are confirmed. In the event of the Physician's unplanned absences, Patient's calls to the Physician or to the Physician's office will be directed

[1] as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations.

to a provider who is “covering” for the Physician during his absence. Drs Lupold and Mellinger will make every effort to arrange for coverage but cannot guarantee such coverage.

12. **Change of Law**. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

13. **Severability**. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the contract will stay in force as originally written.

14. **Reimbursement for Services Rendered**. If this Agreement is held to be invalid for any reason, and the CLINIC is required to refund fees paid by You, You agree to pay the CLINIC an amount equal to the fair market value of the medical services You received during the time period for which the refunded fees were paid.

15. **Amendment**. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties. Except for amendments made in compliance with Section 12, above.

16. **Assignment.** This Agreement, and any rights You may have under it, may not be assigned or transferred by You.

17. **Legal Significance**. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that You have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

18. **Miscellaneous**. This Agreement shall be construed without regard to any rules requiring that it be construed against the party who drafted the Agreement. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

19. **Entire Agreement**. This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

20. **No Waiver**. In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party’s requirement or duty under this agreement (for example notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

21. **Jurisdiction**. This Agreement shall be governed and construed under the laws of the State of Pennsylvania. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the CLINIC in Strasburg, PA.

22. **Service.** All written notices are deemed served if sent to the address of the party written above or appearing in Appendix B by first class U.S. mail.

23. **Patient Understandings:**

- This Agreement is for ongoing primary care and is not a medical insurance agreement.
- I do NOT have an emergent medical problem at this time.
- I am enrolling (myself and my family if applicable) in Practice voluntarily.
- I understand that I am enrolling in a membership-based practice that will bill me monthly.
- In the event of a medical emergency, I agree to call 911 first.
- I understand Physicians at Alere Family Health will make every effort to be available but may not always be able to see me on a same-day basis. I may be referred to an urgent care for same-day service.
- I do NOT expect the practice to file or fight any third-party insurance claims on my behalf.
- This Agreement does not meet the individual insurance requirement of the Affordable Care Act.
- This Agreement is non-transferable.
- I understand failure to pay the membership fee will result in termination from Practice.

The parties may have signed duplicate counterparts of this Agreement on the date first written above.

_____
Chris Lupold, MD, for
ALERE FAMILY HEALTH, LLC

_____ _____
Signature of Patient Name of Patient (printed)

_____
Date

APPENDIX A
SERVICES

1. **Medical Services:** Medical Services under this agreement are those medical services that the Physician is permitted to perform under the laws of the State of Pennsylvania, are consistent with Physician's training and experience, are usual and customary for a family medicine physician to provide, and include the following:[2]

    • Acute and Non-acute Office Visits
    • Well-Woman Care/ Pap Smear
    • Chronic Disease Management
    • Well-Child Care
    • Sports Physicals
    • Electrocardiogram (EKG)
    • Blood Pressure Monitoring
    • Diabetic Monitoring
    • Spirometry
    • Breathing Treatments (nebulizer or inhaler with spacer)
    • IUD Removal
    • Urinalysis
    • Rapid Test for Strep Throat
    • Removal of benign skin lesions/warts
    • Simple aspiration/injection of joint
    • Trigger point injections
    • Removal of Cerumen (ear wax)
    • Wound Repair and Sutures
    • Abscess Incision and Drainage
    • Ingrown Toenail Removal
    • Basic Vision/Hearing Screening
    • Convenience of access to many commonly prescribed medications at reduced prices
    • Drawing basic labs. Labs and testing that cannot be performed in-house will be offered at a discounted rate through select vendors.[3]

The Patient is also entitled to a personalized, annual in-depth "wellness examination and evaluation," which shall be performed by the Physician, and may include the following, as appropriate:

    • Detailed review of medical, family, and social history and update of medical record;
    • Personalized Health Risk Assessment utilizing current screening guidelines;

[2] As deemed appropriate and medically necessary by the Physician.
[3] Patient is responsible for all costs associated with pathology, laboratory testing, and specimen analysis.

• Preventative health counseling, which may include: weight management, smoking cessation, behavior modification, stress management, etc.;
• Custom Wellness Plan to include recommendations for immunizations, additional screening tests/evaluations, fitness and dietary plans;
• Complete physical exam & form completion as needed.

2. **Non-Medical, Personalized Services.** CLINIC shall also provide Patient with the following non-medical services ("Non-Medical Services"):

a. **After Hours Access.** Patient shall have direct telephone access to the Physician seven days per week. Patient shall be given a phone number where Patient may reach the Physician directly for guidance regarding concerns that arise unexpectedly after office hours. Video chat and text messaging may be utilized when the Physician and Patient agree that it is appropriate.

b. **E-Mail Access.** Patient shall be given the Physician's e-mail address to which nonurgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member of CLINIC in a timely manner. **Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that Patient could reasonably expect may develop into an emergency.** Patient agrees that in such situations, when a Patient cannot speak to Physician immediately in person or by telephone, that Patient shall call 911 or go to the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

c. **No Wait or Minimal Wait Appointments.** Reasonable effort shall be made to assure that Patient is seen by the Physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If Physician foresees a minimal wait time, Patient shall be advised of the projected wait time.

d. **Same Day/Next Day Appointments.** When Patient calls or e-mails the Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. If Patient calls or e-mails the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Physician by the following normal office day. In any event, however, CLINIC shall make every reasonable effort to schedule an appointment for the Patient on the same day that the request is made.

e. **Specialists Coordination.** CLINIC and Physician shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. **Patient understands that fees paid under this Agreement do not include and do not cover specialist's fees or fees due to any medical professional other than the CLINIC Physician.**

APPENDIX B
PATIENT ENROLLMENT

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the Alere Family Health Agreement Form.

Printed Name	Date of Birth (MM/DD/YYYY)	Age

Street Address	City, State, Zip

Home Phone	Work Phone	Cell Phone	Preferred email

Spouse Name	Date of Birth (MM/DD/YYYY)	Age

Home Phone	Work Phone	Cell Phone	Preferred email

Child/Children to Whom this Agreement Applies:

Print Name	Date of Birth (MM/DD/YYYY)	Age

Print Name	Date of Birth (MM/DD/YYYY)	Age

Print Name	Date of Birth (MM/DD/YYYY)	Age

Print Name	Date of Birth (MM/DD/YYYY)	Age

I certify that I have read, understand, and agree to the terms set forth in the Alere Family Health Agreement Form. I further certify that I have received a copy of this form.

Signature: _____

Emergency Contact(s)

Name: _____

Relationship: _____

Phone Number: _____

Can Alere Family Health, LLC discuss your medical information with above named person?

Yes(initial)_____ No(initial)_____

Name: _____

Relationship: _____

Phone Number: _____

Can Alere Family Health, LLC discuss your medical information with above named person?

Yes(initial)_____ No(initial)_____

APPENDIX C

MEMBERSHIP FEES

Enrollment Fee - This is charged when Patient enrolls with Practice and is nonrefundable. If a patient discontinues membership and wishes to re-enroll in the practice we reserve the right to decline re-enrollment or to require a re-enrollment fee of $200.00.

Monthly Periodic Fee - This fee is for ongoing primary care services.

Initial Enrollment Fee:

$25 for first member; $15 for each additional member in household enrolled at same time.

Monthly Periodic Fees:

Individual (per member)

Ages:	0-18 years of age	$30 per month ($15 with parent membership)
	18-25 years of age (student)	$30 per month ($15 with parent membership)
	19-64 years of age	$60 per month
	65+ years of age	$90 per month

- OR –

Family Plan (per family)

- $150 per month
- "Family" is defined as members of a shared household
- May include 2 adults (Age 64 or less) and 2+ children (legal dependents age 25 or less)

APPENDIX D
MEDICARE OPT OUT AND WAIVER AGREEMENT

Alere Family Health, LLC
Chris Lupold, MD
334 Hartman Bridge Rd
Ronks, PA 17572

Phone 717-925-4869

Fax 717-983-4722

Private Contract

This agreement is between Chris Lupold, M.D., whose principal place of business is 334 Hartman Bridge Rd, Ronks, PA 17572, and

Beneficiary: _____

Who resides at: _____

_____

Medicare ID #:_____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on July 1, 2017. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been

covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on:

_____
Date

By:

_____
Beneficiary or his/her legal representative

And:

_____
Chris Lupold, M.D.

APPENDIX D
MEDICARE OPT OUT AND WAIVER AGREEMENT

Alere Family Health, LLC
Susan Mellinger, MD
334 Hartman Bridge Rd
Ronks, PA 17572

Phone 717-687-2082

Fax 717-983-4723

Private Contract

This agreement is between Susan Mellinger, M.D., whose principal place of business is 334 Hartman Bridge Rd, Ronks, PA 17572, and

Beneficiary: _____

Who resides at: _____

_____

Medicare ID #:_____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on April 1, 2018. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been

covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on:

_____
Date

By:

_____
Beneficiary or his/her legal representative

And:

_____
Susan Mellinger, M.D.

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice is effective August 1, 2017
If you have questions about this notice, please contact:
Alere Family Health, LLC
Attn: Privacy Officer
334 Hartman Bridge Rd
Ronks, PA 17572