Privacy Disclosure & Policies

This notice describes how your medical information may be used and disclosed (provided to others) and how you can gain access to this information. Please review this notice carefully.

As a patient of Gateway Urgent Care (GUC) you have the right to know how your private, confidential healthcare and personal information is being protected.

Under the law you have the right (with certain limitations) to: - Inspect and request copies of your records. GUC may charge a reasonable fee for record copies. If for any reason your request to inspect or receive copies of your health information is denied, we will inform you or the reason. Request that your health care provider append information to your medical record. Receive a notice of your privacy rights by your health plan upon enrollment and when privacy practices are amended. Obtain a copy of GUC privacy policy GUC is required, under specific circumstances, to use or disclose your protected health information without your written authorization. Examples include: - Public Health activities; judicial & administrative proceedings; correctional institutions & other law enforcement situations - Disclosure regarding victims of abuse neglect, or domestic violence; health oversight activities. - Law enforcement; military & veteran activities - Government programs providing public benefits & workers compensation - Coroners, Medical Examiners and Funeral Directors Use of Health Information GUC may use your protected health information to provide you with health care services. GUC and entities such as health plans may use your health information for the following purposes:

- Consultations Your doctor may consult with other healthcare practitioners and clinical/laboratory specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax or email are confidential and names are not used unless necessary and consent is provided either verbally or in writing. - Health Care Operations Your doctor may use or disclose, as needed, your protected health information in order to support business activities of our practice. These activities include but are not limited to: quality assessment; training of medical students and staff; licensing and conducting or arranging for other business activities. - Records Released Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted. Releasing records is done by photocopy and is most often mailed. It is sent to whom you requested it for and is accompanied by a Confidential Patient Information Cover Sheet. On occasions when faxing of chart notes is required, a Confidential Healthcare Enclosed Fax Cover Sheet accompanies them.

In-office Security The notes that are taken during appointments are secured by each individual practitioner of GUC through secure Electronic Medical Record (EMR) services. Access to Personal Health Information is limited to healthcare practitioners and employees of GUC. Public Interaction Should your doctor or employees of the clinic see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is your doctor's preference to discuss your health in the office setting only to protect your privacy and to ensure that your personal health information is kept in your chart. General Informed Consent for Care and Treatment TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or

mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

At the time of service Gateway Urgent Care (GUC) collects from you the estimated amount of patient responsibility based on your specific insurance plan, our insurance contracts, and the eligibility information provided by your insurance company. While we do our best to verify your insurance coverage it is your responsibility to ensure that you have an insurance policy in force with benefits that will cover our services. We make no guarantee that your policy will cover any of our services or outside services such as specialists, laboratory or radiology either in network or out-of-network. Following your visit, you will receive an explanation of benefits (EOB) from your insurance company stating the amount paid by your Insurer and the remaining balance owed by you, if any. Patients are financially responsible for all services rendered that are not paid for by their insurance(s). All medical services are billed by GUC and I authorize payment for Insurance benefits, which may otherwise be payable to me, directly to GUC. I authorize the release of Information concerning my (or my dependent's) healthcare, advisement, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that I will be billed directly by and agree to pay GUC for any outstanding balances should my credit/debit card be declined or canceled. I understand that a $10 late fee will be applied to any unpaid balance I owe that is not paid within 30 days. I understand that my account will enter collections after 60 days of non-payment. I agree to reimburse GUC the actual fees of any collection agency, which may be based on a percentage at a maximum of 40% of the unpaid balance, and all costs and expenses, inducing reasonable attorneys' fees Incurred in such collection efforts. If my account is sent to collections, such fees may be assessed by the collection agency on behalf of GUC. I also understand that I may be responsible for my balance due to any charge back, reversal or dispute as a result of my credit card company's or bank's refusal to remit payment to GUC.

ACKNOWLEDGMENT OF PATIENT CHOICE POLICY

In connection with your care, your GUC provider may recommend certain ancillary services as part of your overall care. GUC offers certain ancillary services that patients may require such as x-ray, limited lab services, and certain pharmaceuticals. While GUC makes these services available, we want you to know that if your GUC provider prescribes any of these services for you, you are free to choose any

PATIENT RIGHTS

Additionally, we shall ensure that you are treated with dignity, respect, and consideration and that you are not subjected to Abuse, Neglect, Exploitation, Coercion, Manipulation, Sexual abuse or assault, Except as allowed in AZ R9-10-1012(B), restraint or seclusion, retaliation for submitting a complaint to the Department or another entity, Misappropriation of personal and private property by our personnel member, employee, volunteer, or student. We will ensure that you or your representative, Except in an emergency, either consents to or refuses treatment, May refuse or withdraw consent for treatment before treatment is initiated, Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure. We will also ensure that you informed of our policy on health care directives and the patient complaint process which is to write to the medical director at info@gatewayuc.com. We will obtain consent for any photography except that a patient may be photographed when admitted for identification and administrative purposes. Except as otherwise permitted by law, we will provide written consent to the release of medical or financial information. You also have the following rights: **1.** Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis; **2.** To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities; **3.** To receive privacy in treatment and care for personal needs; **4.** To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01; **5.** To receive a referral to another health

care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient; **6.** To participate or have the patient's representative participate in the development of, or decisions concerning, treatment; **7.** To participate or refuse to participate in research or experimental treatment; and **8.** To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

You also have the right to a hard copy of these rights by asking at the front desk or logging on to your electronic patient portal at any time.

I have read and understand my right to privacy, as stated above, and agree to have GUC maintain my medical information in accordance with its policies and agree to inform the clinic of any special arrangements I need in pertaining to this issue.

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Printed Name

_________________________________ _______________________________
Patient/legal guardian Signature Date