PATIENT AGREEMENT
COMPLETE MEDICINE

This is an Agreement entered into on_____ , 20___, between Complete Medicine, a Texas Professional Limited Liability Company (Practice, Us or We), and_____ (Patient or You).

Background

The PRACTICE is a direct pay endocrinology practice, which delivers endocrinology, diabetes and metabolism medical services through its physicians, Dr. Arti Thangudu (Physician), Dr. Vidhya Illuri (Physician) and Dr. Munira Mehta (Physician) at 9002 Six Pines Drive, The Woodlands, TX 77380. In exchange for certain fees, the PRACTICE 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, which is attached and a part of this Agreement.

Agreement

1. **Electronic Agreement.** The Parties agree that the Patient's acknowledgment and acceptance of these terms via electronic means, including but not limited to checking a box, clicking "I Agree," or submitting an online form, shall constitute the Patient's valid and binding signature and agreement to this Contract, with the same force and effect as a handwritten signature.

2. **Term**. This Agreement will last for **six (6) months** or **twelve (12) months**, beginning on the date it is signed, based on the membership duration selected by the patient.

3. **Renewal.** This Agreement will automatically renew for the same term (monthly, six or twelve months) on the anniversary of the original start date unless either party provides 30 days written notice of cancellation prior to the renewal date.

4. **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. You may cancel this Agreement at any time by providing **30 days written notice**. The Practice may also terminate this Agreement with 30 days written notice.

5. **Payments and Refunds – Amount and Methods.** In exchange for the Services, You

agree to pay the Practice a membership fee as outlined in Appendix C, based on the six-month or twelve-month membership option you select.

(a) The full membership fee is payable **in advance or month to month**, either:

- **Every month $300 per month - labs and nutritionist are not included in this option**
- **Every six (6) months** for a six-month membership, or
- **Every twelve (12) months** for a twelve-month membership.

(b) The parties agree payment is due upon signing this Agreement and upon each renewal, unless otherwise specified.

(c) The Parties agree that All payments shall be made via **automatic debit/credit card** or **automatic bank draft**.

(d) The Patient understands and agrees that timely payment is a **material condition** of this Agreement. Failure to pay within **30 days** of the due date shall result in **termination** of this Agreement and the physician-patient relationship.

(e) Patient is responsible for **all fees associated with procedures, laboratory tests not included in the membership, and specimen analyses**. These fees are **due at the time of service**.

(f) Once the patient has completed their **initial visit**, **no refunds** will be issued.

(g) If the Agreement is cancelled by either party before the end of the selected membership term and at least **24 business hours before the initial visit occurs,** we will:

- Refund any **unused portion** of your fees, **or**

- If the value of the services you received exceeds the fees paid, you shall reimburse the Practice for the **difference**, calculated based on the Practice's **usual and customary fee-for-service rates** (available upon request).

3. Non-Participation in Insurance. Your initials on this clause of the Agreement acknowledges the Patient's understanding that neither the PRACTICE, 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. _____ **(Initial)**

4. Medicare. Your initials on this clause of the Agreement acknowledges 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. _____ **(Initial)**

5. 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 PRACTICE, or its employees. The Patient acknowledges that the PRACTICE 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 PRACTICE, and for hospitalizations and catastrophic events. _____ **(Initial)**

6. **Communications**. The Patient acknowledges that although PRACTICE 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 PRACTICE, and its Physicians to communicate with him/her by e-mail 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 PRACTICE 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 e-mail or text message within 24 hours, You agree that you will contact the Physician by telephone**

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

or other means.

(f) Technical Failure. Neither the PRACTICE, 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 PRACTICE'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 PRACTICE; or (v) Patient's failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

7. **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 Appendix A. In order to assist Patients in scheduling non-urgent visits, PRACTICE will notify Patients of any planned Physician absences as soon as the dates are confirmed. In the event of the Physician's unplanned absences, the practice will have a covering physician available to cover urgent needs.

8. **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.

9. **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 Agreement will stay in force as originally written.

10. **Reimbursement for Services Rendered.** If this Agreement is held to be invalid for any reason, and the PRACTICE is required to refund fees paid by You, You agree to pay the PRACTICE 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.

11. **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.

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

13. **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.

14. You understand and agree that this Agreement is legally binding whether signed electronically or by traditional means on hardcopy.

15. **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.

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

17. **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.

18. **Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Texas. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the PRACTICE in San Antonio, Texas.

19. **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.

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

_____
Arti Thangudu, MD, for
COMPLETE MEDICINE, PLLC

_____ _____
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 Texas, are consistent with Physician's training and experience, are usual and customary for a endocrinology, diabetes and metabolism physician to provide, and include the following:[2]

- Diabetic Monitoring
- Thyroid Disease Treatment
- Hypertension Monitoring
- Hyperlipidemia Monitoring
- Transgender Medicine
- In-depth Nutrition Counseling
- Weight Loss Counseling
- Type 2 Diabetes
- Type 1 Diabetes
- Hypoglycemic Disorders
- Thyroid Disorder/Nodules
- Osteoporosis
- Reproductive Hormone Disorders
- Low Tesosterone
- Menopause
- Perimenopause
- At Physician's discretion, additional services may be offered for an additional fee.

*Patient is responsible for all costs associated with any procedures, imaging, non-included laboratory testing, and specimen analysis.

2. **Non-Medical, Personalized Services**. PRACTICE shall also provide Patient with the following non-medical services ("Non-Medical Services"), which are complementary to our members in the course of care:

(a) ***After Hours Access*.** Patient shall have text message and email 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 non-urgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member of PRACTICE in a timely manner. **Patient understands and agrees that email and the internet should never be used to access medical care in the**

[2] As deemed appropriate and medically necessary by the Physician.

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 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 contacted and advised of the projected wait time.

(d) ***Appointments*.** Every reasonable effort shall be made to schedule an appointment with the Physician as soon as available. Based on availability and patient preference, visits may be via phone or video chat.

(e) ***Specialists Coordination.*** PRACTICE 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 other specialist's fees or fees due to any medical professional other than the PRACTICE Physician.**

APPENDIX B
PATIENT ENROLLMENT

Monthly fees, as set out in Appendix C, shall apply to the following Patient(s):

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

APPENDIX C
FEE ITEMIZATION

Patients may choose one of the following membership terms:

Membership Term	Rate	Includes
6-month membership	$1,800 (paid in full)	Biannual labs (as recommended and ordered by physician), quarterly nutritionist visits, access to care as outlined in Appendix A
12-month membership	$3,600 (paid in full)	Biannual labs (as recommended and ordered by physician), quarterly nutritionist visits, access to care as outlined in Appendix A
Month-to-month membership	$300/month charged monthly	Labs and nutritionist not included and will be provided at an additional fee

Note:

- Biannual laboratory testing is included **at physician discretion**.
- Additional labs or diagnostics outside of those ordered by the physician will be **billed separately.**
- Membership will **automatically renew** for the same term unless 30 days written notice is provided prior to the renewal date.
- **No refunds** are provided after the **initial visit** has occurred.
- Nutritionist and laboratory services are given as a courtesy for our patients. **No refunds** will be issued if laboratory and nutritionist services are unused.

Initial Enrollment Fee

$300 one-time enrollment fee

- Includes:
    - **$300 one-time enrollment fee** (non-refundable if membership is cancelled less than 24 business hours prior to scheduled appointment)

What the $300 Enrollment Fee Covers:

Onboarding a new patient requires additional time and resources from our physicians and care team. This fee supports the following:

- Retrieval of medical records from other clinicians
- Thorough review of your past medical history and records
- Time-intensive coordination of initial prescriptions
- Completion and submission of **insurance prior authorizations**
- Completion and submission of **insurance appeals** as needed

Reactivation:

- If membership **lapses or is terminated**, the **$300 enrollment fee** must be paid again to resume services.
- Enrollment fee is **subject to change** in the future.

APPENDIX D
MEDICARE OPT OUT AND WAIVER AGREEMENT

This agreement (Agreement) is entered into by and between Complete Medicine, a Texas Professional Limited Liability Company, Dr. Arti Thangudu (Physician), Dr. Vidhya Illuri, and Munira Mehta, DO whose principal address is 9002 Six Pines, The Woodlands, TX 77380 and _____, a beneficiary enrolled in Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997 (Beneficiary), who resides at _____ _____, _____, Texas_____. The Physician has informed Patient that Physician has opted out of the Medicare program and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Introduction

The Balanced Budget Act of 1997 allows physicians to "opt out" of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, physicians are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the physicians not opted out of Medicare). In essence, the physician must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years.

This Agreement between Beneficiary and Physician is intended to be the contract physicians are required to have with Medicare beneficiaries when physicians opt-out of Medicare. This Agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Physician Responsibilities

(1) Physician agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.

(2) Physician agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

(3) Physician agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent medical situation.

(4) Physician agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Physician also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

Beneficiary Responsibilities

(1) Beneficiary agrees to pay for all items or services furnished by Physician and understands that no reimbursement will be provided under the Medicare program for such items or services.

(2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Physician for such items or services.

(3) Beneficiary agrees that s/he is not currently in an emergency or urgent health care situation.

(4) Beneficiary agrees not to submit a claim to Medicare and not to ask Physician to submit a claim to Medicare.

(5) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Physician that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

(6) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare.

(7) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.

(8) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

(9) Beneficiary acknowledges that a copy of this contract has been made available to him/her.

Medicare Exclusion Status of Physician

Beneficiary understands that Physician has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

Duration of the Contract

This contract becomes effective on _____, 20____, and will continue in effect until _____, 20_____. Either party may terminate treatment with reasonable notice to the other party, as provided in the agreement. Notwithstanding this right to terminate treatment, both Physician and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

Successors and Assigns

The parties agree that this agreement will be fully binding on their heirs, successors, and assigns.

Physician and Beneficiary intend to be legally bound by signing this agreement on the date set forth below.

_____
Name of Beneficiary (printed)

_____
Signature of Beneficiary

_____
Date

COMPLETE MEDICINE

By:_____
Arti Thangudu, MD

Date Signed by Physician and Professional Limited Liability Company:

_____, 20_____.

COMPLETE MEDICINE
9002 Six Pines The Woodlands, TX 77380
(210) 591-8649

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 GAIN 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 (IIHI). 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 health information that identifies you. We are also 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 IIHI. 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 IIHI
- your privacy rights in your IIHI
- our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI 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 for 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 office 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 QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

COMPLETE MEDICINE
Attn: Privacy Officer
9002 Six Pines The Woodlands, TX 77380

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI, unless you object:

1. **Treatment.** Our practice may use your IIHI 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 IIHI in order to write a prescription for you, or we might disclose your IIHI 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 IIHI in order to treat your or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as other healthcare providers, your spouse, your children or your parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your IHII to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI 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 IIHI to evaluate the quality of care you received from us, to develop protocols and clinical guidelines, to develop training programs, and to aid in credentialing, medical review, legal services and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter 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.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

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

1. Public Health Risks. Our practice may disclose your IIHI 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 regarding 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 agency (ies) and authority (ies) 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 IIHI 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 IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery 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 has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a 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 has 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 IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI 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 IIHI 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 IIHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI:

The health and billing records we maintain are the physical property of Complete Medicine. The information in it, however, belongs to you. You have a right to:

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** requests. 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 IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only 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 IIHI, 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 of the IIHI 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 IIHI. 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 IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created 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 non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" 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 period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right 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 with our practice, contact:

COMPLETE MEDICINE
Attn: Privacy Officer
9002 Six Pines Drive, The Woodlands TX 77380

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 and 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 IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have questions regarding this notice or our health information privacy policies, please contact the Privacy Officer listed above.

Acknowledgement

I hereby acknowledge that I have received and read Complete Medicine's Notice of Privacy Practices, as required by HIPAA. I understand that I may request additional copies of this notice at any time.

_____ _____

Patient Name Date