

CLINIC GENERAL CONSENT

Arkansas Health Group is a company which employs healthcare providers and owns clinics across the state. The language in this document applies to all clinic providers and locations. Your consent for treatment will remain in effect until revoked in writing.

CONSENT: I voluntarily consent to receive medical and healthcare services from an Arkansas Health Group clinic. I understand this may include services by my physician, his or her assistants and designees, including medical students, residents or fellows, and employees of Arkansas Health Group as is deemed necessary or advisable in their judgment. I authorize the use of telehealth services, photographs, camera surveillance and/or audio and video recordings as needed for the purpose of treatment, payment or healthcare operations. I authorize the disposal of any tissues removed in the performance of any procedure. I am aware that the practice of medicine and surgery is not an exact science; that it involves my informed acceptance of certain risks versus benefits and I acknowledge that no guarantees have been made to me as a result of my examination and/or treatments.

CONTACT BY PHONE:

COMMUNICATIONS REGARDING MY ACCOUNT:

I agree that Arkansas Health Group, any other collection or servicing agency, or agencies retained by Arkansas Health Group (together referred to hereafter as "collectors") to collect any money that I owe to Arkansas Health Group may contact me by telephone or text message at any number associated with my personal demographic information. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

COMMUNICATIONS REGARDING MY CARE:

I agree that Arkansas Health Group may contact me by telephone or text message at any number associated with my personal demographic information for the purpose of care coordination, quality improvement activities, appointment reminders, wellness campaign reminders and insurance coverage/network status. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that Arkansas Health Group may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

RELEASE OF INFORMATION AGREEMENT: I understand Arkansas Health Group will generate, receive and store protected health information regarding my diagnosis and /or treatment. This information could include mental illness information, use of drugs and alcohol, or communicable diseases such as HIV/AIDS. I understand that the Notice of Privacy Practices provides information about how Arkansas Health Group and its workforce may use and/or disclose my information for the purposes of treatment, payment, healthcare operations and otherwise required by law. I hereby authorize Arkansas Health Group, in its discretion, to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Baptist's charge or who may be responsible for determining the necessity, appropriateness, amount, or other matter related to treatment or charges, including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, and the Social Security Administration or its intermediaries or carriers. I further authorize Arkansas Health Group, in its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier and to my employer when said employer is actually liable for such charges.

CLINIC FINANCIAL POLICY

INSURANCE COVERAGE: Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payment and/or estimated coinsurance and deductibles prior to seeing the provider. In the event we accept assignment of benefits, the patient is still ultimately responsible for all charges.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You are responsible for the timely payment of your account.

MOTOR VEHICLE ACCIDENTS: In the event you are involved in a motor vehicle accident, you are expected to pay for services when rendered. We will gladly provide you with all the necessary paperwork to file your insurance claim with your carrier.

NON PAYMENT: If your account is over 60 days past due, you will receive a letter that you have 20 days to pay your account in full. If the balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this clinic.

MISSED APPOINTMENTS AND PAPERWORK COMPLETION: The clinic will be charging a nominal fee for the completion of paperwork outside a scheduled visit. Additionally, the clinic will be charging \$25 for appointments that are not kept or canceled with less than 24 hour notice. This policy will apply once you have missed or canceled with less than 24 hour notice the second appointment with this clinic.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign any and all rights and benefits to which I may be entitled arising out of any healthcare or liability insurance policy, Medicare or Medicaid to Arkansas Health Group. I authorize the full and undiscounted pursuit of payment on my account from any available liability insurance policy or third party source before submission of my account for payment to my own health insurance company or to Medicare or Medicaid. I hold Arkansas Health Group harmless of any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: Notification; Precertification; Prior to Retrospective Authorization; or Utilization Review of the medical services I receive. Assignment of Insurance benefits is valid and binding until final payment of the account is received.

FINANCIAL RESPONSIBILITY AND PAYMENT REQUEST: The undersigned, jointly and severally, in consideration for the services rendered to the above named patient, accepts financial responsibility and agrees to pay in advance any applicable deductibles, copayments, coinsurance and estimated self pay dollars and to pay in arrears the clinic's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my qualification for financial assistance. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges for certain physicians' services furnished by specialists, and physicians for whom Arkansas Health Group is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I agree that I am financially responsible for deductibles and co-insurance not covered by my insurance.

NOTICE OF PRIVACY PRACTICES

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.

To Our Patient: The physicians and staff of Baptist Health are committed to the protection of your health information. The Health Insurance Portability and Accountability Act, requires that we provide notice to each of our patients of how this information is used. We safeguard information about your health and your person (Protected Health Information, PHI). We collect information from you and keep it in a designated record set that contains your health and billing information.

This Notice of Privacy Practices describes the privacy practices of the health care organizations that are a part of Baptist Health that have collectively formed an Affiliated Covered Entity or "ACE" under the HIPAA regulations for purposes of HIPAA compliance (the "Baptist Health ACE"). The Baptist Health ACE includes hospitals, clinics and other health care providers that the organizations operate. Our rules to protect your privacy will be followed by all workforce members of the site where you are being treated, as well as physicians and other health care practitioners with permission to provide services at our sites. This Notice of Privacy Practices also describes the privacy practices of the physicians and other health care professionals on our medical staffs ("Practitioners"), and other health care providers that provide health care services in our hospitals, clinics and other sites. Legally this is called an "organized health care arrangement" or "OHCA" between the Baptist Health ACE and eligible providers on its Medical Staff. Because the Baptist Health ACE is a clinically-integrated care setting, our patients receive care from Baptist Health ACE staff and from independent practitioners on the Medical Staff. The Baptist Health ACE and its Medical Staff must be able to share your health information freely for treatment, payment and health care operations as described in this Notice. Because of this, the Baptist Health ACE and all eligible providers on the Baptist Health ACE's Medical Staff have entered into the OHCA under which the Baptist Health ACE and the eligible providers will:

- Use this Notice as a joint notice of privacy practices for all inpatient and outpatient visits and follow all information practices described in this notice
- Obtain a single signed acknowledgment of receipt
- Share health information between healthcare settings with eligible providers so that they can help the Baptist Health ACE with its health care operations

Accordingly, this Notice will be followed by (1) our workforce members and (2) the independent physicians and other Practitioners who are not employees, agents, servants, partners or joint ventures of Baptist Health or its Affiliates. All Practitioners are solely responsible for their judgment and conduct in treating or providing professional services to patients and for their compliance with state and federal laws. Nothing in this Notice is meant to imply or create an employment relationship between any independent physician or other Practitioner and us. We use a joint Notice of Privacy Practices and a joint Acknowledgement Form with independent physicians and other practitioners to reduce paperwork and make it easier to share information to improve your care. This Notice does not change or limit any consents for treatment or procedures the patient may sign during the time the patient receives care from any of us.

The OHCA does not cover the information practices of practitioners in their private offices or at other practice locations.

1. ACCESS/USE/DISCLOSURE AND YOUR PROTECTED HEALTH INFORMATION

Treatment: We will use and disclose your PHI to provide you with health care treatment or services. This includes sharing PHI among health care providers involved in your care, both inside and outside of Arkansas Health Group. Sharing PHI among providers promotes a collective, comprehensive approach to care. This communication may be accomplished by using a secure electronic method.

- Your health care provider may share information about your condition with pharmacists to discuss appropriate medications, or with radiologists or other consultants to make a diagnosis.

- Different departments may share your PHI to coordinate such things as prescriptions, dietary needs, physical therapy, social work, psychiatric support, lab work and diagnostic imaging, etc.

Your care may involve the use of telemedicine equipment. Security measures (such as encryption and/or the use of non-public networks) are used to help minimize the risks associated with telemedicine.

Payment: Your protected health information will be used, and disclosed as necessary, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services such as determining eligibility and coverage and utilization review. For example,

- Obtaining approval from your insurance company for your admission and continued stay.

Healthcare Operations: We will use or disclose your PHI in order to support the business activities of Arkansas Health Group. These activities include, but are not limited to, quality assessment and improvement activities, recruitment and training of medical personnel, licensing, risk management, legal services, compliance and audit functions, etc.

Arkansas Health Group participates in a number of online public social media sites. If you or others choose to share your health information on our online social media sites, this information is considered to be public and not protected by privacy laws, and may be re-posted or shared by Arkansas Health Group or others. If

you do not want your health information to be public, you should not share it on online public social media sites. You may be contacted by Arkansas Health Group regarding fund-raising activities. Any communication will include an option to opt-out of receiving further communications.

We will share your protected health information with third party "business associates" which perform various functions for Arkansas Health Group. Whenever an arrangement such as this involves the access/use or disclosure of your protected health information, we will have a written contract that contains terms that will protect your privacy. For example,

- A contract exists between Arkansas Health Group and certain entities that help improve patient care and operational efficiency.

- A contract exists between Arkansas Health Group and the revenue cycle vendors who work patient accounts.

The workforce and business associates of the medical staff and other healthcare providers may also require access to your protected health information to perform their job functions. To protect your privacy, Arkansas Health Group requires written authorization from the provider before access is granted. This access may be accomplished by using a secure electronic method.

We may participate in certain health information exchanges (HIEs) whereby we may disclose your health information, as permitted by law, to other health care providers or entities for treatment, payment, or health care operations purposes.

2. OTHER USES AND DISCLOSURES BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. For example,

- Use and disclosure of psychotherapy records

- Use and disclosure of PHI for marketing

- Disclosures that constitute the sale of PHI

⁹ You may revoke your authorization at any time in writing. There may be cases where Arkansas Health Group has already released your protected health information prior to the revocation of the authorization.

3. DISCLOSURES TO WHICH YOU HAVE THE OPPORTUNITY TO OBJECT

Facility Directory: Unless you object, we will place your name and location in our facility directory. This information will be disclosed to people who ask for you by name. Unless you object, we will maintain your religious affiliation for use by clergy of the same religious affiliation.

Others Involved in your Healthcare: Unless you object, we may discuss your protected health information with family members or close friends. The information disclosed will only be that related directly to this person's involvement in your care. If you are unable to agree or disagree, we may disclose this information if we determine that it is in your best interest based on our professional judgment. For example,

- We may notify your family of your admission to the hospital.

- We may discuss your discharge plan with the individuals participating in your care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Communication Barriers: We may use and disclose your protected health information if we are unable to obtain consent from you but feel in our professional judgment that you intend to consent.

4. USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include, but are not limited to:

Required by Law: We will disclose your protected health information when required to do so by federal, state, or local law.

Public Health Reporting: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive information.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your information to health oversight agencies for activities authorized by law such as audits, investigations, and inspections.

Abuse and/or Neglect: We may disclose your protected health information to a governmental entity or agency authorized by law to receive reports of suspected abuse/neglect.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects, biologic product deviations, etc.

Legal Proceedings: If you are involved in a lawsuit, we may disclose your protected health information in response to a court order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process from someone else involved in the lawsuit, but only if efforts have been made to tell you about the request or to obtain an order from the court.

Law Enforcement: We may disclose protected health information, so long as applicable requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death or injury has occurred as a result of criminal conduct, (5) in the event that a crime occurs on property owned or operated by Arkansas Health Group, and (6) in the event of a medical emergency.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for them to perform other duties as required by law. Your protected health information may also be disclosed to a funeral director, as authorized by law, in order for the director to carry out their duties. We may disclose such information in the reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye, or tissue donation purposes.

Research: Your protected health information may be used for the purpose of research in the form of concurrent or retrospective chart review. This would occur with your permission or after we've received approval from a special board whose members review and approve the research project. We may also disclose your protected health information to the Baptist Health Center for Clinical Research to determine if you could benefit from participating in a clinical trial. If so, you may be contacted to see if you are interested.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel, (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Other Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et seq.

5. YOUR RIGHTS

You have the right to inspect and obtain a copy of your protected health information. This means that you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain your protected health information. A designated record set contains medical and billing records and any other records that we use in making decisions about you. You may request the records be provided in paper or electronic format. You may be charged a fee for the cost of copying, mailing, or supplies associated with your request.

Patients are also encouraged to use the Arkansas Health Group portal to access their protected health information. Enrollment information can be found at www.baptist-health.com. Use of the portal is free.

Under federal and state law, however, you may be denied access to inspect or obtain a copy. Depending on the circumstances, the decision to deny access may be reviewable.

Please contact the medical records department at your clinic if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom this restriction applies. You may also request restriction of PHI to a health plan with respect to health care for which you have paid for in full out of pocket. The request and payment must occur in writing in advance of the services being provided.

The hospital/physician is not required to agree to the restriction that you request, except in the case of a requested restriction of PHI to a health plan for purposes of payment or healthcare operations with respect to health care for which you have paid for in full out of pocket. If the hospital/physician believes that it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of any alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the privacy contact listed below.

You have the right to request an amendment to your protected health information. This means that you may request an amendment of protected health information about you in a designated record set for as long as we maintain the information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy. Please contact the appropriate medical record department if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made for purposes outside those for treatment, payment, and healthcare operations. You have the right to receive specific information regarding non routine disclosures that occurred after April 14, 2003. We must respond within sixty (60) days. You may request a shorter timeframe. You are entitled to receive one (1) free accounting each year. There will be a fee for any additional accounting requests during the year. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a copy of this notice from us. Upon request, you may receive an additional paper or electronic copy of this notice from us.

You have the right to receive a notice following a breach of your unsecured PHI.

6. COMPLAINTS

If you believe your privacy rights have been violated by Arkansas Health Group, you may file a complaint with us by contacting the Arkansas Health Group Privacy Officer at 501-202-1323. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint. We will not require you to waive the right to file a complaint with HHS as a condition to receive treatment from us.

7. ADDITIONAL INFORMATION

This notice was updated, published and becomes effective on September 8, 2020. Arkansas Health Group has a duty as your healthcare provider to maintain your privacy, abide by the terms of this privacy notice, and provide you with a revised copy of this notice if revisions are made.

We reserve the right to change this notice. We reserve the right to make the revised notice effective for protected health information we already have as well as any information we create or receive in the future.

Patient Signature:

Mode Of Consent:

If patient is unable to consent or is a minor, complete the following:

Patient is 18 y.o. or is unable to consent because:

I am legally authorized to execute the above by virtue of my relationship to the patient as

Signature of Person Giving Consent:

Print Name of Person Giving Consent

Two (2) Witnesses Required for Verbal or Telephone Consent:

Witness Signatures: