EMPOWER FAMILY MEDICINE
MEMBER AGREEMENT

Empower Family Practice, L.L.C.
This is an Agreement between Empower Family Medicine, L.L.C., a Georgia professional corporation, located at 209A Swanton Way Suite 101, Decatur, GA 30030, and you, (**Principal Member**). Melissa Black M.D. (**Physician**) serves in the capacity as an agent of Empower Family Medicine (**EFM**).

PRINCIPAL MEMBER: (Financially responsible party – patient, parent, adult child, guardian or employer.)

Name: _____

Primary Mailing Address: _____

Phone Numbers: _____

Email: _____

PATIENT MEMBERS:

Please relist Principal Member if they will also be a patient. Do not list if parent or employer only.

Name	Address	Date of Birth
	☐ Same as Principal	

(Please attach additional sheet if enrolling more than 4 patients.)

Background
The Physician, who specializes in family medicine, delivers care on behalf of EFM, at the address set forth above. In exchange for certain fees paid by the Principal Member, EFM through its Physician, agrees to provide Patient Members with the Services described in this Agreement on the terms and conditions as follows.

1. **Definitions**
   - **A. Patient Member**. A Patient Member is defined as those persons for whom the Physician shall provide Services, and who are signatories to, or listed above as Patient Members, and incorporated by reference, to this agreement.
   - **B. Principal Member.** A Principal Member is defined as the persons who are financially responsible for enrollment and membership fees. The Principal Member may or may not also be a Patient Member.
   - **C. Membership**. EFM is a physician-owned and managed medical practice. Membership in EFM is defined as eligibility for medical services, non-medical services, and Amenities as defined in Appendix 1.
   - **D. Physician**. A Physician is an independent contractor. EFM provides services through its Physician.
   - **E. Services**. As used in this Agreement, the term Services, shall mean a package of services and both medical, non-medical (collectively "Services") as defined in Appendix 1 included in the price of membership.
   - **F. Amenities**. As used in this Agreement, the term Amenities, shall mean services provided for a fee separate from the enrollment and monthly membership fee, billable directly to the Patient Member. A list of Amenities is provided in Appendix 1.

2. **Service Provision**. In exchange for an initial enrollment and monthly membership fee paid by the Principal Member, EFM shall provide medical and non-medical Services for Patient Members as outlined in Appendix 1.

3. **Services Excluded**. Membership in EFM does not include immunizations, medical devices, emergency medical services, hospital care, radiology, or other specialty healthcare needs. Referrals may be made for these services when necessary.

4. **Fees.** EFM will not bill or be responsible to submit or collect any health insurance benefits for any services rendered under the Membership. The Principal Member shall be responsible for the following costs:

   A. Initial Enrollment Fee. The Principal Member shall pay an Initial Enrollment Fee of $150.00 to activate each Patient Member's participation. The Initial Enrollment Fee shall be paid upon execution of this Agreement on or before the date of initial consultation. The Initial Enrollment Fee includes an initial visit, history and physical exam, and Services as noted in Appendix 1 for the remainder of that month.

   B. Monthly Membership Fee. The Principal Member shall pay a recurring membership fee of $75.00 per month billed on the first day of each month beginning the month after the initial enrollment and consultation. The monthly membership fee shall be automatically renewed.

5. **Payment. Preferred method of payment is recurring monthly credit or debit charge.** Please complete authorization for subscription (billed as $75 per month) and automatic billing (authorization to bill as needed for office procedures) through PayPal. The Principal Member shall pay to EFM an Initial Enrollment Fee, as well as a Monthly Membership Fee which shall be charged via the preferred method of payment. The Monthly Membership Fee shall be automatically charged from the account on the first day of each month, beginning in the month following enrollment. **Payment for Amenities** including but not limited to lab work, acupuncture, dermatologic, gynecologic and other procedures, are billed to the Patient Member at the time of service via credit or debit card transaction through Paypal only. **Cash or check payments are not accepted**.

6. **Terms.** This Agreement shall commence on the date signed by the parties below and shall continue for a period of one month, automatically renewed.

7. **Non-Participation in Insurance**. Patient Member acknowledges that neither EFM, nor the Physician participate in any health insurance or HMO plans or panels and has opted out of Medicare. Neither of the above make any representations whatsoever that any fees paid under this Agreement are covered by your health insurance or other third party payment plans applicable to the Patient or Principal Member. The Patient Member shall retain full and complete responsibility for any such determination. If the Patient Member is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient Member will sign a separate agreement acknowledging that any services provided by EFM are not reimbursed by Medicare. Medicare cannot be billed for any services performed for you by the Physician. You the Patient Member, agree not to bill Medicare or attempt Medicare reimbursement for any such services. Patient Member shall renew and sign a separate Medicare Opt Out agreement annually.

8. **Insurance or Other Medical Coverage**. Principal and Patient Members acknowledge and understand that this Agreement is not an insurance plan, and is not a substitute for health insurance or other health plan coverage (such as membership in an HMO). Membership in EFM will **not** cover hospital services, or any services not personally provided by EFM, or its Physicians. Patient Member acknowledges that EFM has advised that Patient Member obtain or keep in full force such health insurance policy(ies) or plans that will cover Patient Member for general healthcare costs. Principal and Patient Members acknowledge that this Agreement is not an Agreement that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that Patient Member may carry.

9. **Termination**. This Agreement will commence on the date first written above and will extend monthly thereafter. Notwithstanding the above, Principal/Patient Member and EFM shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving 30 days prior written notice to the other party. Unless previously terminated as set forth above, at the expiration of the initial month's term (and each succeeding monthly term), the Agreement will automatically renew for successive monthly terms upon the payment of the monthly fee at the beginning of the Agreement month.

10. **Refunds**. EFM does not refund membership or enrollment fees. If termination is requested by either Principal Member, Patient Member, or EFM, it will become effective 30 days after notice of termination. Any membership fee usually billed in those 30 days will be applied without refund. Upon notice of termination, Patient Member may continue to access Services until the last day of the month which has been paid. For example, if notice of termination is given on June 15th,

billing will continue for 30 days with the last bill for monthly membership issued on July 1st, and the last day of service would be July 31st.

11. **Cancelled Appointments**. Patient Member shall be charged $25 if a Patient Member cancels his or her appointment within 12 hours of the scheduled appointment or otherwise fails to attend the scheduled appointment. The fee will be $150 for a new patient appointment that is missed or cancelled within 24 hours of the scheduled appointment time (advance payment is non-refundable). Three unexplained no-shows in the span of one year will result in termination of membership.

12. **Communications**. Patient Member acknowledges that communications with the Physician using email, facsimile, video chat, instant messaging, and telephone are not guaranteed to be secure or confidential methods of communication. As such, the Patient Member expressly waives the Physician's obligation to guarantee confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may become a part of your medical record.

    By providing an email address, Patient Member authorizes the EFM, and its Physicians to communicate with Patient Member by email regarding their "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and it's implementing regulations) By inserting an email address in Exhibit A, Patient Member acknowledges that:

    A. Email is not necessarily a secure medium 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 email communications confidential and secure, neither EFM, nor the Physician can assure or guarantee the absolute confidentiality of email communications.
    C. Email communications may be made a part of Patient Member's permanent medical record; and,
    D. Patient Member understands and agrees that email is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information.

    In the event of an emergency, or a situation in which the member could reasonably expect to develop into an emergency, Patient Member shall call 911 or the nearest emergency room, and follow the directions of emergency personnel.

    If Patient Member does not receive a response to an email message within one day, Patient Member agrees to use another means of communication to contact the Physician. Neither EFM, nor the Physician will be liable to Patient Member for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient Member as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address email messages, (iii) failure of the EFM's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of email communications by a third party; or (v) Patient Member's failure to comply with the guidelines regarding use of email communications set forth in this paragraph.

13. **Medical Records**. Member shall pay for the cost of all copies of his or her medical records requested by them. Copying cost is $0.50 per page.

14. **Change of Law.** If there is a change of any law, regulation or rule, federal, state or local, which affects the Agreement including these Terms & Conditions, which are incorporated by reference in the Agreement, or the activities of either party under the Agreement, or any change in the judicial or administrative interpretation of any such by federal, state, or local law or regulation ("Applicable Law"), and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights, obligations or operations associated with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement including these Terms & Conditions. If the parties are unable to reach an agreement concerning the modification of the Agreement within 45 days after the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party.

15. **Severability**. If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

16. **Reimbursement for services rendered.** EFM does not provide refund or reimbursement for any services rendered by EFM.

17. **Amendment.** No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties. Notwithstanding the foregoing, EFM may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending Principal and Patient Members 30 days advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by EFM, except that Patient Member shall initial any such change at EFM' request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

18. **Assignment**. This Agreement, and any rights Principal or Patient Member may have under it, may not be assigned or transferred by Principal or Patient Member.

19. **Relationship of Parties**. Patient Member and the Physician intend and agree that the Physician, in performing his/her duties under this Agreement, is an independent contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor, and the Physician shall have exclusive control of his work and the manner in which it is performed.

20. **Legal Significance**. Patient Member acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient Member also acknowledges having had a reasonable time to seek legal advice regarding the Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of the Agreement.

21. **Notices.** All notices and information relating to this Agreement and Plan shall be provided in writing and delivered to the mailing address of the Principal/Patient Members indicated on page 1 of this Agreement or, if to EFM, delivered to the address provided below: Empower Family Medicine LLC, 209A Swanton Way, Suite 101, Decatur, GA 30030. All written notices are deemed served if sent to the address of the party written above or appearing in Exhibit A by first class U.S. mail.

22. **Applicability**. This Agreement is intended solely for the benefit of the Principal Member and Patient Members whose names are indicated on this Agreement. EFM reserves the right to exclude any individual from participation in Membership. All Principal and Patient Members shall sign this Agreement, thereby consenting to and agreeing to all of the terms and conditions of this Agreement. A parent or guardian shall sign on behalf of all minors or incapacitated parties who are under this Agreement. All parents or guardians of minors or incapacitated persons who are listed as Patient Members, further agree to be financially responsible for all cost and services provided to such minor and/or incapacitated person.

23. **Counterparts**. To respect the privacy of each Patient Member, this Agreement may be executed with multiple copies of this Page 6, each of which shall indicate the signature of a separate adult Patient Member, and all of which shall be deemed to be integral parts of this Agreement.

24. **Miscellaneous;** This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are used for convenience only and shall not limit, broaden, or qualify the text.

25. **Entire Agreement**: This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement.

26. **Jurisdiction:** This Agreement shall be governed and construed under the laws of the State of Georgia and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for EFM's address in Decatur, Georgia.

27. Agreement to Alternative Dispute Resolution: Patient Member understands and agrees to the following: a.) That any claim or dispute arising out of or related to the provision of healthcare services now or in the future to the member by Empower Family Medicine or its employees shall be resolved by final and binding arbitration, as governed by the terms of the Federal Arbitration Act; b.) that this does not include and encompass any claim or dispute by either party related to billing or payment for services; c.) That by agreeing to arbitrate, all parties waive the right to a jury trial (if otherwise available); d.) That this agreement is also binding on any individual claiming on behalf of the Patient Member; e.) That this agreement is voluntary and is not a precondition to receiving health services; f.) That the arbitration of any claim or dispute hereafter shall be conducted in the State of Georgia in accordance with the Rules and Procedure of Henning Arbitration and Mediation Services Inc. a copy of which is available upon request; g.) That Patient Member has the right to revoke this agreement no later than ten (10) days following signature and that, if choosing to revoke Patient Member must request and execute a revocation from within this time period.

_____ _____ _____

Patient Member or HCPOA Sign Print Date

MEMBER AGREEMENT

I have reviewed the EFM Member Agreement, been given the opportunity to ask questions about its content, and consent to its terms. Signed & Dated,

_____ _____ _____

Patient Member or HCPOA Sign Print Date

_____ _____ _____

Principal Member, If other than Patient Member Sign Print Date

_____ Melissa Black M.D. _____

Physician Owner, EFM LLC Sign Print Date

INSURANCE INFORMATION

EFM does not bill insurance for routine physician services. Your insurance information is kept on file to be disclosed to other care providers who may help facilitate your care upon request, such as LabCorp, home health, hospitals etc.

Insurance Payer	Plan Name	Member ID	Effective Dates	Phone Number

EXHIBIT A - ELECTRONIC COMMUNICATIONS

Principal and Patient Members have acknowledged that electronic correspondence including email, instant messaging of any kind, video chat or telephone communications may not be secured and information exchanged by these methods may be accessible by others. For exchange of sensitive private, protected health information, Patient Members are advised to speak in person with their physician or utilize the secured, patient portal.

_____ _____ _____

Patient Member or HCPOA Sign Print Date

_____ _____ _____

Principal Member, If other than Patient Member Sign Print Date

Appendix 1
Medical Services.

As used in this Agreement, the term Medical Services shall mean those medical services, provided by EFM, that the Physician, him/herself is licensed and permitted to perform under the laws of the State of Georgia that are consistent with his/her training and experience as a family medicine physician, as the case may be. Membership in EFM includes the following Medical Services:

1. Primary Health Care Services: EFM shall provide office-based Medical Services to the Patient Members listed on page 1 of this Agreement (in accordance with the limitations of Paragraph 3 below).

A. Well/preventive office visits, which are visits for the preservation of physical and mental wellness, discussion of preventive guidelines, nutrition and exercise.
B. **Treatment of immediate problems**, including but not limited to treatment of sore throats, coughs, colds, and minor injuries.
C. Management of long-term medical conditions including but not limited to, asthma, diabetes, and high blood pressure.
D. Care coordination to assist other health team members by organizing and forwarding pertinent information from primary exams for use by specialists for laboratory tests and x-rays, among other specialized treatment needs.

2. Urgent Medical Care. A Patient Member who has an acute illness or is otherwise in need of urgent medical care for a condition which is not life-threatening and who calls EFM's membership phone number at (404) 981-8833 between Monday and Friday before 2:00 PM or on a weekend or holiday before 12:00 noon, shall receive a return call from a physician at EFM before 5:00 p.m. that same day. The majority of calls will be returned within 60 minutes, unless the Physician is with a patient. After a telephone consultation with the Patient Member, the Physician will determine, within his/her sole discretion, whether the illness or medical condition requires same-day physician care. If same-day physician care is warranted, arrangements will be discussed with the Patient Member to determine whether an office visit, phone visit, web video visit, Urgent Care or Emergency Room visit is most appropriate. If same-day care is not warranted in the Physician's discretion, the Patient Member shall be scheduled for an appointment on the next calendar day which is not a weekend day or holiday as soon as possible.

3. Physician Absence. The Physician may from time to time, due to vacations, sick days, and other similar situations, not be available to provide the services referred to in Appendix 1. During such times, Patient Member calls to the Physician will be routed to a message indicating absence from duty and what time full service is expected to resume. If Patient Members have a concern which is urgent and the Physician is absent from duty, they should proceed to the nearest urgent or emergent care facility.

Non-Medical Services.

EFM shall also provide Patient Member with the following Non-Medical services ("Non-Medical Services"):

1. Continuous Access. Patient Member shall have access to the Physician via direct telephone, email and patient portal on a continuous basis as best possible. During routine visits Patient Members will receive training on how best to communicate needs with the physician, such that non urgent needs are communicated during business hours and urgent needs are directly called whenever necessary. In the uncommon event that the Physician is off duty due to illness, vacation or other unforeseen emergency, Patient Members will have continuous access to their online patient portal so their medical record is available for review by an alternative healthcare provider whenever necessary.

2. **Email Access.** Patient Member shall be given the Physician's email address to which non-urgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member of the EFM in a timely manner. Patient Member 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 Member 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 the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

3. No Wait or Minimal Wait Appointments. Every effort shall be made to assure that Patient Member is seen by the Physician immediately upon arriving for a scheduled office visit or after only a minimal wait.

4. Same Day/Next Day Appointments. When Patient Member calls or emails 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 the patient calls or emails 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 on the following normal office day. In any event, however, EFM shall make every reasonable effort to schedule an appointment for the Patient Member on the same day that the request is made.

5. Home Visits. Home visits to homebound elderly Patient Members within the City of Decatur may be made on a limited basis at the discretion of the Physician.

6. Specialists. EFM Physician shall coordinate as needed with medical specialists to whom Patient Member is referred to assist Patient Member in obtaining specialty care. Patient Member understands that fees paid under this Agreement do not include and do not cover specialists' fees or fees due to any medical professional other than the EFM Physician.

Amenities

Amenties include medical procedures requiring medical supplies. Amenities are offered at a separate fee from enrollment and membership fees. Amenities may include but are not limited to lab work, tuberculosis screening (PPD), ear irrigation, skin biopsy, skin lesion removal, wound care, laceration repair, suture or stitch removal, pap smear, fecal occult blood testing, trigger point injection, joint aspiration, joint injection, EKG, and acupuncture. A fee scale for Amenities is available in the clinic and is subject to change at any time.

EMPOWER FAMILY MEDICINE
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.

If you have any questions about this notice, please contact Melissa Black MD, Founder and Privacy Officer, at Empower Family Medicine.

WHAT IS HIPAA? The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a law designed to protect patient's protected health information (PHI). The U.S. Department of Health and Human Services ("HHS") issued a Privacy Rule to implement the requirement of HIPAA regarding the use and disclosure of individuals' PHI by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

IS EMPOWER FAMILY MEDICINE (EFM) bound by HIPAA as a "Covered Entity" ?
No. Covered entities bound by HIPAA regulations, are those that electronically transmit health information to the government or insurance companies. As a direct primary care provider opted out of government and private insurance plans, to whom you the patient pays in full for services, EFM is not a HIPAA Covered Entity.

Per the CMS Website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/ "Health Care Providers. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA Transactions Rule.6 Using electronic technology, such as email, does not mean a health care provider is a covered entity."

Despite being a non-covered entity, EFM seeks to maintain the privacy of protected health information. This document provides notice of our privacy practices regarding health information about you.

SECURED COMMUNICATION OF PROTECTED HEALTH INFORMATION. As a patient members of EFM, you may communicate health information with your provider by secured / encrypted means. This includes verbal disclosure during a face to face office visit, or via a secured patient portal.

UNSECURED COMMUNICATION OF PROTECTED HEALTH INFORMATION. As a patient members of EFM, you have the option of communication of protected health information by alternative (nonsecured) means. This may include: unsecured email, temporary storage and transfer of health information to consulting care providers via unsecured server, use video chat or skype, mobile or wired telephone communications.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies you ("Health Information").

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project, as long as they don't remove or take a copy of any Health Information.

SPECIAL SITUATIONS: As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we use another company to maintain electronic medical records on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces or foreign military, we may release Health Information as required by military command or foreign military authorities.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties. National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state to conduct special investigations.

Inmates or Individuals In Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official.

This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT
Individuals Involved In Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES
The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Uses and disclosures of Protected Health Information for marketing purposes; and 2. Disclosures that constitute a sale of your Protected Health Information. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:
Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to **Empower Family Medicine LLC, 209A Swanton Way, Suite 101, Decatur GA 30030**. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may

not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable. cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to **Empower Family Medicine LLC, 209A Swanton Way, Suite 101, Decatur GA 30030.**

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **Empower Family Medicine LLC, 209A Swanton Way, Suite 101, Decatur GA 30030.**

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to **Empower Family Medicine LLC, 209A Swanton Way, Suite 101, Decatur GA 30030.** We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket·Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to **Empower Family Medicine LLC, 209A Swanton Way, Suite 101, Decatur GA 30030**. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, To obtain a paper copy of this notice, you must make your request, in writing, to **Empower Family Medicine LLC, 209A Swanton Way, Suite 101, Decatur GA 30030**

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated. you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager at Arbor Family Medicine, PC. All complaints must be made In writing. You will not be penalized for filing a complaint.

EMPOWER FAMILY MEDICINE
PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers (if needed under emergency circumstances).
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed and studied such Notice of Privacy Practices prior to signing this consent. I understand that Empower Family Medicine (EFM) has the right to change its Notice of Privacy Practices, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

I acknowledge that I have been provided with the Notice of Privacy Practices of EFM either in electronic or paper form, that I have been given ample time to read and study it, and that I have been given the opportunity to ask questions regarding its content.

Communicating Protected Health Information

I consent for the staff of EFM to send or receive my health information for the purpose of primary care via:

- ❒ Records request form faxed to other care providers
- ❒ Telephone or fax to other care providers (ex. specialists, hospitalists, rehab services, home services)
- ❒ Unsecured email account (Gmail, Yahoo etc.) via the email I provide
- ❒ Secured, encrypted email (ex. Virtru)
- ❒ Practice Fusion Patient Portal
- ❒ Phone or email contact with my specified individuals in an emergency
- ❒ Phone or email contact with my specified individuals if they contact my physician about my care
- ❒ Unsecure video chat upon request (ex. Skype)
- ❒ Secured video chat upon request
- ❒ Health insurance company information exchange (telephone or fax)
- ❒ Curbside (informal) consultation with colleague care providers, not using personal identifiers (ex.PMG)
- ❒ Temporary File Storage for transfer of information to consulting care providers (ex. Dropbox).

My Specified individuals (List relatives, friends or health advocates who have your permission to communicate about your health with your physician):

Name	Relationship	Phone	Email

	Name on Account	Number	Ok To Leave Message?
Cell			
Home			
Work			

_____ _____ _____

Patient Member or HCPOA Sign Print Date