Community Health Network

PATIENT CONSENT AGREEMENT

PATIENT IDENTIFICATION

THIS PATIENT CONSENT AGREEMENT applies to services provided by Community Health Network, Inc., Community Hospital North, Community Hospital East, Community Hospital South, Community Heart and Vascular Hospital (a facility of Community Hospital East), Community Howard Regional Health, Community Howard Specialty Hospital, Community Physician Network, Community Home Health, Community Surgery Center North, Community Surgery Center East, Community Surgery Center South, Community Surgery Center Hamilton, Community Surgery Center Northwest, Community Surgery Center Howard, Community Surgery Center Plus, Community Endoscopy Center Indianapolis and Community Digestive Center Anderson (each of these health care providers whether individually licensed or operating under the license of another hereinafter referred to collectively as "Community").

Medical Treatment
I request or authorize Community to provide and perform under the direction of my physician(s) and/or his/her designee such care, procedures, services and supplies as are considered advisable for my health and wellbeing. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me by my physician(s) or Community as to the result of any treatments, examinations, procedures or other services provided by Community. I authorize Community to dispose of any tissue, severed or amputated member, body part, or medical device removed in connection with services provided by Community. I understand that it is the responsibility of the physician to explain to me the nature of any diagnostic, therapeutic, medical and/or surgical procedures necessary to treat me and to explain risks and consequences associated with the services.

Patient Rights and Advance Directives
If I am receiving hospital inpatient services, ambulatory surgical center services or home health services, I acknowledge I have been given written materials on my patient rights and responsibilities, which include my right to an advance directive. For all other Community services, I understand that information about advance directives is available upon request.

Consent to Release Medical Records
I understand Community will make every effort to treat my medical record information as confidential; however, I realize information must be shared with other providers involved in my care or in the payment of my care. Further, I understand other healthcare providers involved in my care will have access to my medical information. I consent to the release of my medical information for treatment, payment and health care operational purposes as allowed by state and federal law, including the release of communicable disease information.

Legal Relationships
I understand my services may be provided by: (1) health care providers who are not employees of Community but who have a contract with Community to provide services, such as emergency physicians, anesthesiologists, radiologists, pathologists and other independent physicians; and (2) health care providers who have no employment or other contractual relationship with Community (collectively, "Independent Providers"); and these Independent Providers may or may not participate in my insurance plan. I understand Community is responsible for carrying out the instructions of such Independent Providers, but I acknowledge (a) Independent Providers are not employees or agents of Community; and (b) **Community is <u>not</u> responsible for the medical decisions, acts or omissions of Independent Providers.**

Communications
I authorize Community and its agents to contact me at any telephone number I provide to Community including wireless (cellular) telephone numbers by calling or text messages, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I understand I will be able to opt out of text messages. Community and its agents may also contact me at the email address I provide.

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Assignment of Insurance Benefits

If my insurance is accepted by Community, I assign payment to: (1) Community; and (2) Independent Providers involved in my care. I understand I will receive separate bills for services performed by Independent Providers who may or may not participate in my insurance plan.

I understand Community verifies my benefits and/or bills my insurance plan as a courtesy to me. I authorize Community to release to Medicare and its agents any information needed to determine my benefits for services received. I authorize the release of my medical records and any other information necessary to obtain payment from Medicare, Medicaid and other payers. I request that payment of authorized benefits from Medicare, Medicaid and other insurance plans be made on my behalf to Community for services provided by Community.

Further, I understand verification of my benefits is not a guarantee the insurance plan will pay those benefits and I am responsible for ensuring that any prior authorization required for my services is obtained in advance of treatment. In addition, I hereby appoint Community and its employees and agents as my representative(s) to file grievances and appeals for me with my insurance plan as allowed by Indiana State law.

Responsibility for Payment

I understand that I may request and receive an estimate of anticipated charges. I understand and acknowledge: (1) an estimate is not a guarantee; (2) the estimate is not binding upon Community; and (3) actual charges will be determined based on the services I receive and may be more or less than the estimate. I understand I am financially responsible for all amounts not paid by insurance or other payers for services provided to me by Community and any Independent Providers and I agree to pay all charges when due or in accordance with any financial arrangement made at the time of discharge. Further, if I have overpaid on any account with Community, I agree that the overpayment may be applied to any outstanding charges on other Community accounts.

I understand Community provides financial assistance in the form of reduced charges and payment options to those who qualify. I understand I can request additional information on payment options or financial assistance if I believe I may not be able to pay or may not be able to pay timely. In the event I do not pay such charges when due or I fail to comply with any payment arrangement, I agree to pay costs of collection, including attorney fees and interest and authorize Community or its agent to access my credit report.

Release of Responsibility for Valuables

I understand Community is not liable for personal possessions including, but not limited to, money, valuables, dentures, eyeglasses, hearing aids or other property, that are lost or damaged. I know Community has the right to search anything on its premises, including wallets and purses, for the safety and welfare of its patients and visitors. If Community decides an item could be a threat to health or safety, Community may: (1) dispose of it; (2) put it in a safe; or (3) give it to law enforcement. I know I can avoid having my possessions searched by sending them home.

Pictures and Recordings

I consent to closed circuit monitoring, videotaping, digital or audio recordings, photography and/or images of my care for Community's internal purposes including, but not limited to, identification, clinical care, education, performance improvement and/or safety related purposes. I understand I will be asked to sign a separate consent if a recording or image may be used for external purposes.

Community Health Network

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PATIENT IDENTIFICATION

Receipt of Notice of Privacy Practices
I acknowledge that I have received or have been offered the Community Health Network Notice of Privacy Practices and understand I may also access a copy at www.eCommunity.com.

By signing below, I acknowledge that I have read and agree to pages 1, 2 and 3 of this Patient Consent Agreement and my questions have been answered. Changes will not be accepted to this Patient Consent Agreement. Everything in this Agreement continues and does not expire or terminate. I understand that I can request a copy of this Agreement.

***Patient/Legal Representative Signature**	Date	Relationship (if not patient)
Guarantor Signature (if other than patient/legal representative)	Date	Relationship
Witness Signature	Date	Time

Behavioral Health Office Practices

Welcome to Community Behavioral Health Services. You have taken a positive step towards wellness by coming to Community Behavioral Health Services for treatment. It is our philosophy that we are partners in your progress. We are pleased that we can offer you experienced clinicians who offer group, individual, conjoint therapy, and medication management as an effective and preferred mode of treatment. To help ensure continued treatment success we have outlined important policies and expectations.

1. **Access to Clinician, Clinical Nurse Specialist, or Psychiatrist**: We understand that supportive group and individual counseling alone can be successful in some situations. In others, both counseling and medication are needed to support recovery. You must keep all group and individual counseling appointments in order to continue seeing one of our psychiatrists and progress in your recovery.
2. **Missed Appointments**
    a. It is your responsibility to keep all scheduled group and individual appointments. If you have two consecutive missed appointments, no further appointments will be scheduled without first speaking to your therapist.
    b. If you have a scheduling conflict, 24 to 48 hour cancelation notice is required.
3. **Changes in Personal Address and Phone Number**: It is important for you to keep your therapist and psychiatrist informed of any changes in your situation. Please inform Office Staff of changes in your mailing address or phone number.
4. **Changes in Medication from a Physician Outside of Community Behavioral Health**: As even non-prescription medication can effect treatment and have interaction with other medications you may be taking or are prescribed, please inform your therapist of any changes in medications you are taking.
5. **Payment on your bill**: Payment on your bill is expected at the time you check in for your appointment.
    a. **Co-pays** are due at time of service. This applies to deductibles as well. We will file your insurance claims and bill you for charges not covered. However, be aware that insurance companies will quote what benefits are available, but **do not guarantee coverage**.
    b. **Failure to make two consecutive payments; at time of service may result in disruption or discontinued service**. If this occurs you may appeal the decision to the treatment team.
    c. Persons participating in the Partial Hospitalization or Intensive Outpatient Programs with no income will be required to apply for Medicaid within the first week of services. You will also be required to make a weekly payment on your account.
    d. If you are having problems making payments, a payment plan can be arranged by contacting the Patient Accounting Office at 1-866-424-2317 or 317-621-7620
    e. We understand that there are unusual circumstances regarding payment that may require attention. Should this occur, we will look at each circumstance on a case-by-case basis. Please speak to your therapist concerning this if you feel you have such a circumstance.
    f. If you receive a discount for services from the sliding scale, it is your responsibility to keep your financial agreement updated. Once your financial agreement expires, you will be charged full fee for services. We are unable to go back and discount services if your financial agreement expires.
6. **Responsibilities if you are enrolled as a DMHA Supported Consumer**: If you are enrolled as a DMHA Supported Consumer you must provide your social security number, date of birth, and proof of income. You will have one session from date of application to provide this information.
7. In case of an after-hours emergency, call **1-800-662-3445 or 317-621-5700**.
8. Additional numbers:
    a. Department of Mental Health and Addictions (DMHA) Toll Free Consumer Service Line: 800-901-1133; TTY/ TDD – Dial 711
    b. Indiana Disability Rights Toll Free: 800-622-4845 or 317-722-5555; TTY/TDD – 800-838-1131
    c. Mental Health America of Indiana (MHAI) Mental Health and Addiction Ombudsman Toll Free: 800-555-6424 ext. 239 or 317-638-3501 ext. 239

As a reminder, no firearms or weapons of any sort are allowed on the premises.
Please sign and date this information to acknowledge you have read and understand the content and return to the office staff. Thank you!

Signature: _____ Date: _____

Office Staff Signature: _____ Date: _____

(White copy for chart—Yellow copy for client)

Community Health Network

BEHAVIORAL HEALTH SERVICES CLIENT AGREEMENT

Patient Name: _____

Guarantor Name: _____

Patient Employer Name _____ Spouse Employer Name _____

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Other Income: _____ Other Income: _____

Patient Income: _____ Spouse Income: _____

Total Family Income: _____ # of family members in household: _____

I acknowledge that I have discussed payment policies. I understand their contents. The cost of services to me has been discussed and I understand that I can apply for a _____ percent discount on the treatment costs. I understand that I am not eligible for a discount until I provide income verification, I understand that insurance payments made to Community Behavioral Health by my insurance company will constitute partial payment toward the full cost of service unless insurance pays 100%.

I understand that Community Behavioral Health Services is EXCLUDED from Community Health Network charity applications for medical services and if applicable I would need to apply through Community Behavioral Health.

In order to retain an adjustment fee, this agreement must be reviewed and signed by me every twelve (12) months. You are authorized to check my credit history. We reserve the right to make changes to our sliding fee schedule with a 30 day notice to clients.

Signature of Patient/Legal Guardian: _____

Relationship: _____ Date: _____

Witness: _____ Date: _____

This agreement expires on: _____

Approval Pending: _____ (write in what is required)

Verification of No Income Status

I hereby certify that my family and I have for a period of _____ days/weeks/months, beginning _____ and ending _____, received no income from any source. This verification must be reviewed and renewed in twelve (12) months.

To verify this status, I certify that me and my family's living expenses over the past ___ days/weeks/months, are as follows:

Rent: _____ Utilities: _____ Food: _____ Other: (specify): _____

I have been able to meet the above living expenses (explain): _____

_____

I certify that the above information is true and correct.

_____ _____

Applicant's Signature Date Witness Signature Date

% of discount: _____ Approved ☐ Yes ☐ No

Additional Comments: _____

PAYMENT POLICIES AND AGREEMENT

Community Behavioral Health is a hospital-based mental health center. All fees for service are based on the actual cost of services. Community Behavioral Health will not deny service because of inability to pay. However, Community Behavioral Health may deny service because of refusal to pay. Community Behavioral Health will make every effort to assist you in payment of your account. The following policies and procedures are addressed to the client if of legal age and self-supporting and to the parent or legal guardian if the client is a minor or dependent.

1. Self Pay Policies and Procedures
   A. Because Community Behavioral Health is partially tax supported, fees for which you are directly responsible may be reduced.
   B. At the time of registration you will be asked to complete a Client Agreement which indicates your gross annual income and the number of people supported by that income. The amount of any fee reduction is determined from this statement. Community Behavioral Health requires proof of income. Understating your income willfully and with full knowledge could be considered fraudulent and will be dealt with accordingly.
   C. Verification of income must be provided every twelve (12) months along with your signature on the Client Agreement.
   D. **Fees are to be paid at the time of service. If this is not possible, other payment arrangements must be made in advance. Discuss this with your therapist.**
   E. Unpaid balances will be billed on the monthly basis.
   F. If you are able but unwilling to pay, Community Behavioral Health reserves the right to use a collection agency and/ or terminate services.
   G. Community Behavioral Health reserves the right to make changes to our sliding fee schedule once a year with a 30 day notice to clients.

2. Insurance Policies and Procedures
   A. You are fully responsible for payment of your account. Since Community Behavioral Health is acting solely as an agent in filing claims, it can assume no responsibility for guaranteeing coverage or payment for services rendered.
   B. Provide your insurance identification card at time of your registration.
   C. Sign the authorizations to release information for insurance claim processing and for your insurance benefits to be paid directly to Community Behavioral Health. Failure to sign these authorizations necessitates Community Behavioral Health to bill you the full fees without discount.
   D. Upon settlement of your insurance claim, any unpaid balance will be transferred to a self pay account.
   E. The total amount paid to Community Behavioral Health by you and your insurance company may exceed the total charges for the services. Any overpayment will be promptly refunded or credited to your next visit.
   F. If you have a secondary insurance, it can not be billed until an Explanation of Benefits (EOB) is received by Community Behavioral Health. You will be billed after sixty (60) days if your insurance has not paid.

Medicare Policies and Procedures
   A. Provide your Medicare identification card at the time of your registration.
   B. **Sign the necessary authorization allowing Community Behavioral Health to bill you for services not covered by Medicare.**
   C. If you have supplemental insurance coverage, the above procedures apply.
   D. As a client with Medicare, you will be responsible for paying deductible amounts and for any services not covered by the Medicare program. As with other self pay amounts, fees for services not covered may be reduced based on your family income and size, as described in the self pay procedures.

Medicaid Policies and Procedures
   A. Provide your Medicaid Identification card to the receptionist upon each visit for service.
   B. Sign the necessary authorizations. As a client with Medicaid, Community Behavioral Health must receive prior authorization to treat you. You will be responsible for payment of any services not covered by the Medicaid program.

Other Third Party Payors
Other third payor programs may be available to clients for certain services. Community Behavioral Health assume the responsibility of notifying and explaining these limited programs to qualifies clients.

Your signature on this form indicates that you understand the above policies and agree to be responsible for payment of established fees.

Community Health Network

PATIENT IDENTIFICATION

BEHAVIORAL HEALTH AUTHORIZATION FOR RELEASE OF VERBAL PHI TO A THIRD PARTY

(FOR BEHAVIORAL HEALTH USE ONLY – Not for use for the release of medical records – VERBAL PHI Only)

PATIENT INFORMATION	Name:_____ Date of Birth:_____ Phone:_____ Address:_____
CLINIC/HOSPITAL/ HEALTHCARE PROVIDER (Who has the information you want released?)	☐ Community Hospital North (CHN) ☐ Community Howard Behavioral Health ☐ Gallahue/Outpatient Behavioral Health ☐ Community Hospital East (CHE) ☐ Other location (list below) Clinician:_____ Practice Name_____
WHO MAY HAVE THE INFORMATION	Name:_____ Relationship to Patient:_____
INFORMATION TO BE RELEASED? (Verbal Only)	☐ Condition/Progress ☐ Diagnosis ☐ Medications ☐ Treatment Plan ☐ Other (Be Specific) _____
PURPOSE OF REQUEST?	☐ At the request of the individual ☐ Other (Be Specific)_____
EXPIRATION DATE?	Specific Date:_____ (if no date is listed, expiration date will be 1 year)

A photocopy/fax of this authorization will be treated the same way as an original. No medical records may be released using this authorization.

This authorization may be revoked or cancelled in writing at any time. Any staff member in Behavioral Health may accept a revocation. A cancellation will not change releases that happen before the cancellation. The Community Health Network Notice of Privacy practice describes how to cancel (revoke) this authorization.

Unless otherwise limited, I understand that this release also pertains to information that is protected by either Federal Regulations (42 CFR Part 2) or State law (IC 16-39-2) concerning hospitalization or treatment including but not limited to information regarding treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or for mental health treatment or counseling.

Community cannot prevent disclosure of information by the person or organization who receives verbal information under this authorization and that information may not be covered by federal privacy protections after it is released. By signing this authorization, you release Community from any and all liability resulting from a re-disclosure by the recipient.

I understand that I may refuse to sign this authorization and they my refusal will not affect my ability to obtain services, treatment, or payment for services. I understand that I will receive a copy of this authorization.

I have read and understand this form and authorize release of information as described above.

_____ _____
Patient/Legal Guardian Signature — Authority to act on behalf of patient (Attach Document)

_____ _____ _____
Patient/Legal Guardian Name (Print) — Date — Time

_____ _____ _____
Witness Signature — Date — Time

Request to revoke/cancel the release of information described above.

_____ _____ _____
Patient/Legal Guardian Signature — Date — Time

PLEASE PROVIDE A COPY OF THIS FORM TO THE PATIENT

DIRECTIONS FOR COMPLETING THIS FORM AND HOW TO REVOKE THIS AUTHORIZATION (OFFICE PROCEDURES)

Directions for Completing this Form

PATIENT INFORMATION – Complete the entire section which identifies clearly and legibly all the demographic information specific to the patient (individual for whom in formation is being requested).

CLINIC/HOSPITAL/HEALTHCARE PROVIDER – Identify which from which Community Health Network facility you are seeking information. **Please be specific** in your request. For example, when choosing Community Physician Network, please either the name of the clinician or the practice location you are requesting. If you do not identify a specific facility, records MAY be provided from **ALL** Community Health Network facilities where you have received care. Please seeeCommunity.com for a listing of Community Health Network locations and names.

WHO MAY HAVE THE INFORMATION – Identify the full name of the individual/business is to receive the information and your relationship to this individual/business.

INFORMATION TO BE RELEASED (VERBAL ONLY) – This section gives us instructions on what verbal information you want shared with this individual/business. Please be specific.

PURPOSE OF REQUEST – You are not required to provide a reason for your request; however, this helps us track and assign priority to your request.

EXPIRATION DATE – If you wish to enter a specific date for this authorization to end, you may indicate that date. If no date is listed, the expiration date will be one year from the date signed.

****OFFICE STAFF**** Please scan/index this form to the patient's chart using the document type "Behavioral Health Auth for Release of Verbal PHI". The description will populate for you. Please add the listed individual's name/relationship to the patient. The document date is the date the form was signed. Example: Authorization for Release of Verbal PHI – Sally Smith, Sister

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Directions for Revoking this Authorization – For Office Staff

If a patient wishes to revoke this authorization, please print the original signed copy from the patient's chart and have them sign the bottom "revoke/cancel" portion of the form.

Send the original (not revoked/cancelled) version of the authorization form to Document Corrections with a comment "revoked" and the date it was revoked/cancelled.

Scan/Index the newly signed revoked/cancelled version of the authorization to the patient's chart using the document type "Behavioral Health Auth for Release of Verbal PHI" and a description of "Revoked Authorization for Release of Verbal PHI" and the listed individual's name/relationship to the patient.

Primary Care Contact Information

Community
Health Network

Connect to Care Office
Available 7 days per week to easily connect you to the care you need.

P 317.621.2727 **TF** 855.209.2727
Weekdays 7am – 9pm | **Weekends** 9am – 9pm

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Tobacco Cessation Resource

Community Health Network

Patient Rights and Responsibilities

As a patient of the Community Health Network, you have the right to:

1. Be informed of your patient rights in advance of care being provided or discontinued.
2. Participate in and make informed decisions about your care and pain management, including being able to request or refuse treatment.
3. Have your condition, treatment, pain alternatives and outcomes explained in a manner that you understand. You have the right to interpretation services if needed.
4. Expect timely, and appropriate assessment and treatment of physical pain and emotional or spiritual discomfort.
5. Receive adequate information to consent to or decline participation in clinical research. You may decline at any time without compromising your access to care, treatment and services.
6. Have a family member, friend, clergy, and/or physician notified of your admission to the hospital. You also have the right to request that no information be shared with your family, friends or clergy.
7. Request religious or spiritual support.
8. Receive safe, high quality, medical care, without discrimination, that is compassionate and respects personal dignity, values, beliefs and preferences and contributes to a positive self-image.
9. Receive private and confidential treatments, communications and medical records, to the extent permitted by law.
10. Be free from mental, physical, sexual and verbal abuse, neglect or harassment and/or exploitation. You also have the right to access protective and advocacy services.
11. Be free from physical restraints, seclusion or drugs that are not medically necessary (e.g., ordered for medical emergencies, necessary to ensure the immediate safety of you, a staff member or others) or are used inappropriately.
12. Have complaints reviewed by the hospital. If patients and/or their families wish to report a complaint, please contact the Office of Patient Experience at 317-621-7000 or patientexperience@ecommunity.com. Complaints may also be reported via phone and/or mail to the Indiana State Department of Health (800-246-8909) and/or The Joint Commission (800-994-6610). Patients and/or their families may report complaints to the Indiana State Department of Health and/or The Joint Commission whether or not a complaint with the Office of Patient Experience has been reported.

Indiana State Department of Health
Health Care Facility Complaint Program
2 N. Meridian St, 4B
Indianapolis, IN 46204

The Joint Commission
Office of Quality & Patient Safety
One Renaissance Blvd
Oakbrook Terrace, IL 60181

13. Be informed about transfers to another facility or organization and be provided complete explanation including alternatives to a transfer.
14. Know the name and role of your caregivers (e.g., doctor, nurse, patient support partner, etc.).
15. Request a second opinion.
16. Obtain information as to the relationship of this hospital to other health care institutions.
17. Receive information about continuing your health care at the end of your visit, including home health services.
18. Receive information concerning advance directives (e.g., living will, health care power of attorney, or psychiatric advance directives) and to have your advance directives respected to the extent permitted by law.
19. Be informed of charges, receive an explanation of your bill and receive counseling on the availability of known financial resources for health care services.

As a patient of the Community Health Network, you have the following responsibilities:

1. To respect and be considerate of the rights of other patients and hospital personnel in the control of noise, the number of visitors and to be respectful of the property of other persons and the hospital.
2. To follow the rules of the facility in which you are receiving your care.
3. To provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and insurance benefits.
4. To ask for more information if you have questions about your care, treatment, services or caregivers. It is also your responsibility to report perceived risks in your care and unexpected changes in your condition.
5. To ask the care provider when you do not understand medical words or instructions about your plan of care.
6. To follow the care, treatment, and service plan recommended by your doctor to the best of your ability. If you are unable/unwilling to follow the plan of care, you are responsible for telling your care provider. Your care provider will explain the medical consequences of not following the recommended treatment. You are responsible for the outcomes of not following your plan of care.
7. To tell us how satisfied you are with your care, so that we can resolve problems and learn from them.
8. To assure that the financial obligations of your healthcare are fulfilled as promptly as possible.
9. To abide by the no smoking / no weapons policy of the Network.

A safety message to our patients

At Community Health Network, safety is a team effort. You, as a patient, play a vital role in making your care safe by becoming an active, engaged and informed member of your health care team. Here are several ways you can help:

1. Participate in all decisions about your treatment. You and your doctor should agree on exactly what will be done during each step of your care. It's important to know who will be taking care of you, how long the treatment will last, and how you should feel.
2. If you are unsure about the nature of the illness, ask for a second opinion. The more information you have the more confident you will be in the decisions made. Before you leave the hospital ask about follow-up care and make sure you understand all the instructions.
3. Ask if you have questions or concerns. If you don't understand, please ask us again.
4. You can expect your caregivers to have clean hands. Ask if you are unsure.
5. You can expect your caregivers to introduce themselves and explain what they will be doing.
6. You can expect your caregiver to confirm your identity, by ask your name and date of birth and checking your ID band before administering any medication or treatment.
7. Don't hesitate to call for help when getting out of bed to reduce your risk of falling.
8. Caregivers will check on your needs at least hourly. They will ask you if you have pain, if you need to go to the bathroom, if you want to change position, or if there is anything else they can do for you.
9. Request interpreter services for our non-English speaking patients. We can also provide access to effective communication for hearing impaired patients, including sign language interpreters, assistive listening devices and other auxiliary aids.
10. Read all medical forms and make sure you understand them before signing. If you don't understand them, feel free to ask your physician or nurse to explain them.
11. Ask a trusted family member or friend to be your advocate.
    - Your advocate can ask questions you may not think of while undergoing care.
    - Ask this person to stay with you, even overnight, while you are a patient.
    - Your advocate can help remember answers to questions you may have asked, and speak up for you when you cannot.
    - Make sure this person understands your preferences for care and wishes concerning resuscitation and life support.
12. Know what medications you take and why.
    - Keep a list and be sure to include over-the-counter and herbal medications.
    - Tell your health care provider how you actually take your medications, especially if you take them differently than instructed by your doctor.
    - Consider asking a friend or relative if you need help managing your medications.
13. Share any medication allergies you have with your doctor or pharmacist.
14. When prescribed a new medication, ask if you should avoid certain foods, beverages, other medications or activities while taking the new medication.
15. Be alert to any unexpected changes when picking up your medications. If they look different than what you're used to, ask your pharmacist about it.
16. Ask your pharmacist if you have any questions about your medications.

Thank you for allowing us to serve you. Your safety is of paramount importance to us!

15452B 1117 ESI #20845

Community Health Network

COMMUNITY HEALTH NETWORK, INC.
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.

This Notice describes privacy practices of Community Health Network, Inc., Community Hospital North, Community Hospital East, Community Hospital South, Community Heart and Vascular Hospital (a facility of Community Hospital East), Community Howard Regional Health, Community Howard Specialty Hospital, Community Physician Network, Community Howard Physician Network, Community Home Health, Community Surgery Center North, Community Surgery Center East, Community Surgery Center South, Community Surgery Center Hamilton, Community Surgery Center Howard, Community Surgery Center Northwest, Community Surgery Center Plus, Community Endoscopy Center Indianapolis, Community Digestive Center Anderson, and their affiliates, including: any medical staff members, employees, volunteers, and health care professionals authorized to enter information into your health/medical records (hereinafter referred to as Community Health Network or Network).

I. Our Duty to Safeguard Your Protected Health Information:

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for your health care is considered Protected Health Information (PHI). We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. We are required by law to make sure that your PHI is kept private and to give you this Notice about our legal duties and privacy practices. This Notice explains how, when and why we may use or disclose your PHI. In general, we must access, use or disclose only the minimum necessary PHI to accomplish the purpose of the access, use or disclosure. If we discover a breach of your unsecured PHI, we are required to notify you of the breach.

We must follow the privacy practices described in this Notice, though **we reserve the right to change the terms of this Notice at any time**. We reserve the right to make new Notice provisions effective for all PHI we currently maintain or that we receive in the future. If we change this Notice, we will post a new Notice in patient registration and/or patient waiting areas and post it on our website at www.eCommunity.com. Copies of the Notice currently in effect are available at the registration areas for the providers listed above.

II. How We May Use and Disclose Your Protected Health Information:

We access, use and disclose PHI for a variety of reasons. The following section offers more descriptions and examples of our potential access/uses/disclosures of your PHI. Other uses/disclosures not described in this Notice will be made only with your authorization.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations. Since we are an integrated system, we may share your PHI with designated staff within the Network, for treatment, payment or operations purposes. We also may have these activities performed by other companies on our behalf. Generally, we may access/use/disclose your PHI:

- **For treatment:** We may access/use/disclose or allow others to access/use/disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing or coordinating your health care. For example, your PHI will be shared among members of your treatment team, referring providers, post-acute care facilities, pharmacies, etc. If you are an inpatient, your name may be posted outside the door of your room.
- **To obtain payment:** We may access/use/disclose or allow others to access/use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicare/Medicaid, a private insurer or group health plan to get paid for services that we delivered to you. We may release your PHI to the state Medicaid agency to determine your eligibility for publicly funded services.

- **For health care operations:** We may access/use/disclose your PHI in the course of our operations. For example, we may use your PHI or your answers to a patient satisfaction survey in evaluating the quality of services provided by our staff or disclose your PHI to our auditors or attorneys for audit or legal purposes. We may also share PHI with health care provider licensing bodies like the Indiana State Department of Health. We may allow other providers to access, use or disclose your PHI for some of their healthcare operations purposes, when you are also a patient of that provider. For example, we may share PHI with other providers for quality purposes.
- **Fundraising:** We or our Foundations may contact you to raise money for the Network and its operations, unless you tell us not to contact you for this purpose. You have the right to opt out of receiving fundraising communications from us and we will tell you how to opt out in every fundraising communication.

Uses and Disclosures Requiring Authorization: For other uses and disclosures not described in this Notice, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. You may revoke an authorization by notifying us in writing. If you revoke your authorization, we will stop using/ disclosing your PHI for the purposes or reasons covered by your written authorization as of the date we receive your revocation. Your revocation will not apply to information already released. (See Section VI for instructions on revoking an authorization.) We cannot refuse to treat you if you do not sign an authorization to release PHI, **unless** services provided are solely to create health records for a third party, like physical exam and drug testing for an employer or insurance company; or if treatment provided is research-related and authorization is required for the use of health information for research purposes. We will not sell your PHI or use or disclose your PHI for marketing purposes without your authorization. We will not disclose any psychotherapy notes (as defined by the Health Insurance Portability & Accountability Act) without your authorization.

Uses and Disclosures Not Requiring Authorization: The law allows us to access/use/disclose your PHI without your authorization in certain situations, including but not limited to:

- **When required by law:** We may disclose PHI when a law requires or allows us to do so. For example, we may report information about suspected abuse and/or neglect, relating to suspected criminal activity, for FDA-regulated products or activities, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For public health activities:** We may disclose PHI when we are required or allowed to collect information about disease or injury or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.
- **For health oversight activities:** We may disclose PHI to the Indiana State Department of Health or other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** We may disclose PHI relating to an individual's death to coroners, medical examiners, funeral directors, and organ procurement organizations.
- **For research purposes:** In certain circumstances, and under supervision of an Institutional Review Board, we may disclose PHI in order to assist medical research, such as comparing the health and recovery of all patients who received one medicine to those who received another.
- **To avert a threat to health or safety:** In order to avoid a serious and imminent threat to the health or safety of an individual or the public, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Law enforcement:** We may disclose PHI to a law enforcement official in circumstances such as: in response to a court order; to identify a suspect, witness or missing person; about crime victims; about a death that we may suspect is the result of a crime; or a crime that takes place at our facility.
- **For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons, such as protection of the President.
- **Workers' Compensation:** We may disclose your PHI to your employer or your employer's insurance carrier for Workers' Compensation or similar programs that provide benefits for work-related illness or injuries.
- **Inmates:** An inmate of a correctional institution does not have the rights listed in this Notice.

Uses and Disclosures Requiring You to Have an Opportunity to Object: In the following situations, we may disclose your PHI if we tell you about the disclosure in advance and you have the opportunity to agree to, prohibit, or restrict the disclosure, and you do not object. However, if there is an emergency situation and you cannot be given the opportunity to agree or object, we may disclose your PHI if it is consistent with any prior expressed wishes and the disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further uses or disclosures for patient directory purposes as soon as you are able to do so.

- **Patient Directories:** If you are hospitalized, your name, location, general condition, and religious affiliation may be put into our patient directory for use by callers or visitors who ask for you by name and by clergy. If you ask to be a "No Information" patient, volunteers, employees and telephone operators will **not** tell **anyone** that you are in the facility and flowers, mail, phone calls and visitors will be turned away and not accepted if your room number is not provided.
- **To families, friends or others involved in your care:** We may share with your family, your friends or others involved in your care information directly related to their involvement in your care or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or your death.
- **Disaster relief:** In the event of a disaster, we may release your PHI to a public or private relief agency, for purposes of notifying your family and friends of your location, condition or death.

III. Your Rights Regarding Your Protected Health Information:

You have the following rights relating to your PHI:

To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. You must make your request in writing. If you have paid in full for a service and have requested that we not share PHI related to that service to a health plan, we must agree to that request. For any other request to limit how we use or disclose your PHI, we will consider your request, but are not required to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. If agreed upon, these restrictions will only apply to the Network affiliates listed in the beginning of this Notice. You understand that restrictions will not apply to disclosures already made. We cannot agree to limit uses/disclosures that are required by law.

To request confidential communication: You have the right to ask that we send you information at an alternative address or by an alternative means, such as contacting you only at work. You must make your request in writing. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed. If you request a copy of your PHI in an electronic format, we will provide an electronic copy, if the PHI is readily producible in the electronic form that you've requested. You have a right to choose what portions of your information you want copied and to have information on the cost of copying in advance.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. Written requests must include a reason that supports your request. We will respond within 60 days of receiving your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if we determine that the PHI is: (1) correct and complete, (2) not created by us and/or not part of our records, or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial reviewed, along with any statement in response that you provide, added to your record. If we approve the request for amendment, we will change the PHI, inform you that the change has been made, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released, except as listed below. (This is called an accounting of disclosures.) Your request can relate to disclosures going as far back as six years. The list will not include any disclosures made: for treatment, payment or health care operations purposes; that you have authorized; for national security purposes; through a facility directory; or to law enforcement officials or correctional facilities. Your request must be in writing. We will respond to your written request for such a list within 60 days of receiving it. There will be no charge for the first list requested each year. There may be a charge for subsequent requests.

To receive a paper copy of this Notice: You have a right to receive a paper copy of this Notice and/or an electronic copy by e-mail upon request. To obtain a copy of this Notice, contact one of the individuals identified in Section V. below.

IV. How to Complain About Our Privacy Practices:

If you think we may have violated your privacy rights or if you disagree with a decision we made about access to your PHI, you may file a complaint with a person listed in Section V. below. You may also submit an anonymous complaint by calling 1-800-638-5071. You may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized if you file a complaint.**

V. Contact Persons for Information or to Submit a Complaint:

If you have questions about this Notice or complaints about our privacy practices, please contact:

- Marti A. Baker, Lead Compliance Consultant, 317-621-7321, mabaker@eCommunity.com;
- Dea Kent, Director of Risk Management, Community Home Health, 317-621-4815 DKent@eCommunity.com;
- Leslee Llantz, Senior Compliance Analyst, Community Howard Regional Health, 765-776-8462, Llantz@communityhoward.org; or
- Jackie Smith, VP Compliance, 317-621-7324, Jackie.Smith@eCommunity.com.

VI. Instructions for Revoking an Authorization:

You may revoke an authorization to access, use or disclose your PHI, in writing, except: 1) to the extent that action has been taken in reliance on the authorization or 2) if the authorization was obtained as a condition of obtaining insurance coverage and the insurer is questioning a claim under the policy. Your written revocation must include the date of the authorization, the name of the person or organization authorized to receive the PHI, your signature and the date you signed the revocation. Written revocation must be addressed to: Health Information Management, Release of Information, 1500 N. Ritter Ave., Indianapolis, IN 46219. Such revocation will **not** be effective until received by the Network.

VII. Effective Date:

This Notice was updated on 7/10/2018.