WHITE PINE
MENTAL HEALTH & WELLNESS

Patient Rights and Responsibilities/Consent for Treatment

Our desire is to form a partnership with you in support of your mental health. Your participation is crucial. The interest and commitment you bring to this work is essential to achieving significant improvement in your mental health concerns.

This document is to help you understand your rights and responsibilities as well as our expectations throughout treatment.

YOUR RIGHTS:

To be treated with dignity and respect at all times.
To access medical care and habilitation regardless of your race, religion, gender, ethnicity, age, or sexual orientation.
To have your treatment and other patient information kept private.
To know about all treatment choices, regardless of the cost, and to participate in the choice of treatment.
To consent or refuse treatment. Consent can be withdrawn at any time. Refusal cannot be sole grounds for termination by the provider.
To obtain a copy of your treatment plan by completing a release form.
To contact Alabama Disability Advocacy Program (205 348 4928) or DisAbility Rights Idaho (866 262 3462).

YOUR RESPONSIBILITIES:

To give your provider any information relevant to your care.
To notify your treating provider if or when there are concerts about your treatment plan.
To notify your treating provider of any medication changes, including over the counter medication, medications prescribed for you by other healthcare professionals, and supplements.
To present on time for all scheduled appointments.
To ensure refill requests are made at appointments. If any refills are needed outside of appointment times, 72 hours notice is required.
To act in a mutually respectful manner with all representatives of White Pine Mental Health & Wellness.
To ask your treating provider any questions you may have about your care so that you can better understand your care and your role in it.
To follow your treatment plan and instructions for your care, once that care has been agreed upon by you and your treating provider.
To pay for clinical care feels in full prior to appointment or to have most current insurance information on file.

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I have read and fully understand my rights and responsibilities in my partnership with Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness in providing my care, and agree to adhere to them. I acknowledge that I have received a copy of this statement. Failure to adhere to any patient responsibilities listed above may result in dismissal from the practice. Further, I hereby consent to outpatient treatment and give permission for the clinician to provide the services deemed necessary or advisable in the diagnosis and treatment of the patient. I am aware that the practice of medicine is not an exact science and that there are risks and benefits to any treatment. I acknowledge that no guarantees have been made as to the result of treatment provided by Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness. I understand that the patient has the right to withhold consent to any medical service that is deemed necessary or advisable by the clinician.

My signature below indicates my understanding and approval of the above.

_____ Date: _____

Printed Name of Patient

_____

Signature of Patient

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Office Policies

APPOINTMENTS: Services are by appointment only. This time slot has been reserved just for you. In the event of an emergency, every effort will be made to work you into the schedule. It is recommended that you plan to login to your appointment early.

CANCELLATIONS or LATE ARRIVALS: Cancellations for non-emergencies must be made 48 business hours in advance. In the event that you need to cancel an appointment on a Monday, cancellation must be done on Friday by 5 PM in order to avoid being charged. **Cancellations made less than 48 hours in advance will be charged a $100 fee. You will also incur this fee if you arrive more than 10 minutes past your scheduled appointment time.** If you have incurred this fee, it will be taken automatically from a credit card on file as all patients are expected to keep a zero balance. Follow-up appointments will not be made if there is a balance on your account.

MISSED APPOINTMENTS: In the event that you need to miss your appointment for a non-emergency, we ask that you notify the office so that we may late cancel your appointment. **If you miss your appointment without notifying the office, the card on file will be automatically charged the full fee of your appointment.** This is $145 for a follow up appointment and $290 for initial appointments. Excessive missed appointments may result in discharge from the practice.

REQUESTS FOR RECORDS: If you have an appointment with another provider or request medical information for any reason, you must notify Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness at least five days before they are needed. This will allow your provider sufficient time to prepare documentation for you. In the event that you need records sooner, a few may be charged.

BILLING: Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness is only contracted with a small panel of insurance carriers. It is your responsibility to know what your insurance carrier will or will not reimburse. For patients not utilizing insurance benefits, a fee of $290 will be charged for new patient visits and $145 for follow-up visits at the time of service. For patients with insurances with which we are contracted, a balance will be posted as soon as an Explanation of Benefits is received and this will be charged to the card on file immediately. The insurance adjusted amount may be higher than the cash rate listed above depending on your insurance benefits.

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PAYMENT POLICY: Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness requires payment in full at the time of balance. You are required to keep a credit card on file with this office in the event of a no-show appointment/late cancellation. Payment may be made in the form of cash, check (to Kathryn Werner, PA-C, PC) or credit card. It is your responsibility to notify the office if the card on file needs to be updated. Any returned checks or failed credit card payments will incur a $25 fee. It is required to have a credit card authorization form on file with our office and a current card entered into Luminello.

CONFIDENTIALITY: What is shared between you and your provider will be held in strict confidence. Please see the Patient Privacy Notice for more specific details about your Private Health Information. Information will only be shared if the patient has signed a release of information. Please be aware that the following circumstances are exceptions to confidentiality: a) Patient is a physical danger to self. b) Patient is a physical danger to others. c) Child or elder abuse/neglect is suspected.

MESSAGES: All messages will be returned as promptly as possible. No messages will be checked on weekends or standard holidays. If you need urgent assistance, you may call the provider on call at (208) 391-7280. You may incur a fee for phone conversations over 10 minutes in length. In the event of an emergency, call 911 or go to the nearest emergency department for treatment. Please be aware that providers at White Pine Mental Health & Wellness do not provide inpatient treatment for patients.

REFILLS: Refills will typically be handled during your office visit. No routine prescriptions will be refilled after 5 PM during the week, on weekends, or holidays. Check your medications regularly to be sure that you have enough. We are closed on Fridays. Please allow 72 hours for prescription refill requests to be processed. If you have any medication questions, please contact the office. If you miss an appointment and need a refill, you will need to be seen prior to a refill being sent to your pharmacy. You are strongly encouraged to have your pill bottles available at each appointment to ensure that you have enough medication.

CONTROLLED SUBSTANCES: We do not prescribe any controlled substances (including but not limited to stimulants for the treatment of ADHD, sedative hypnotics for the treatment of insomnia, or benzodiazepines for the treatment of anxiety). We use only non-scheduled medications at our practice. We are happy to discuss non-controlled substances for your needs but will not be able to prescribe any controlled substances.

COURTESY: Please provide your full attention during your appointment. If you are not able to provide adequate attention, we reserve the right to reschedule your appointment. Rude or disruptive behavior by the patient or those accompanying the patient that is directed towards any provider, staff or other people associated with White Pine Mental Health & Wellness could result in termination of the provider-patient relationship.

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TERMINATION: At times, termination between a patient and provider is necessary. Termination of treatment may occur at any time and may be initiated by either the patient or the provider. Reasons for termination by the provider are generally due to non-compliance with treatment, missed appointments, or violation of office policies. If you have any questions about this, please discuss with the provider. In the event that your care needs to be transferred to another psychiatric provider, Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness will provide assistance as able.

FEES: Fee structures are subject to change based on the severity of presenting concerts, appointment length, and services provided. The providers at White Pine Mental Health & Wellness have your best interest in mind and alter their scheduling to accommodate meeting your needs. Fees may be added to your account for both direct and indirect patient care for the following purposes listed below. We value you as a patient of the practice and should you have any questions or concerns, please feel free to discuss any pricing or financial issues with the practice manager or owner. For transparency, our fees are also listed on our website.

1. White Pine Mental Health & Wellness will complete applicable forms or paperwork for any patient that has been seen in the last four weeks. There is a $25 fee for paperwork to be completed outside of your scheduled office visit. We will make every attempt to complete forms during your office visit if time allows for this, but cannot guarantee this can be completed. In the event that these forms require more time and resources, additional fees may occur; however, you will be notified prior to being charged. In the event that you need a form completed with less than 72 hours notice, you may be charged an additional fee. No forms for medical leave or school withdrawal will be completed at a new patient appointment.
2. We value our time with our patients and want to make sure that you are able to discuss what you need during your appointment. Your initial evaluation is generally 60 minutes long and follow-ups are typically 20-30 minutes. In the event that you need or want additional time, there is a $70 extended service fee for each 15 minutes past your appointment end time if scheduling allows. If there is not time for the extension, an additional follow up appointment may be needed.
3. A provider is available to you 24 hours a day, 7 days a week by phone for urgent matters. Please note that any issues that require longer than 10 minutes will be charged at a rate of $35 per ten-minute interval. If you are in crisis, please call 911 or go to the nearest emergency department.

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Please feel free to request a copy of this document for your own records if needed.

The undersigned acknowledges reading and understanding the policies for Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness.

_____ Date of Birth: _____
Printed Name of Patient

_____ Date:
Signature of Patient

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Communication Waiver

Kathryn Werner, PA-C DBA White Pine Mental Health & Wellness may contact me via any phone number or email address listed in my patient portal regarding my appointments, treatment, and information about my health. Messages may be left unless otherwise noted.

By providing my email address in the patient portal, I understand that I give White Pine Mental Health permission to email me on the email address found there. Furthermore, I understand that email is not a HIPAA compliant form of communication, nor is information protected in any way other than basic passwords. I waive any and all liability for Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness in the event of information disclosure that resulted from the use of e-mail.

I understand that for HIPAA compliant, secure communication phone or a message through the patient portal, Lumnello.com, is available.

I acknowledge that I can request alternative communication means at any time. It is my responsibility to communicate in writing any changes to communication preferences.

My signature below indicates my understanding and approval of the above.

_____ Date: _____

Printed Name of Patient

_____

Signature of Patient

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Financial Policies

We do not carry patient balances. All fees are due at the time of service. All patients are required to have a valid credit card or debit card on file in our patient portal.

In the event of a missed appointment without proper notification, the card on file will be charged for the full fee of the appointment. In the event of a late arrival greater than 10 minutes or a cancellation less than 48 hours, the card on file will be charged $100. Cancellations for true emergencies will be rescheduled without a cancellation fee.

You must inform the office if there have been any changes to your payment information. Failure to inform the office of such changes resulting in a declined credit card transaction will result in a $25 charge to your account.

By signing below, you agree to, approve of, and understand all of the following:

- Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness reserves the right to charge the credit card on file, at any time for service provided by the company.
- If your account at Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness carries an outstanding balance for more than 30 days, we reserve the right to charge a late fee of $25.
- If the card on file is declined, we reserve the right to charge a fee of $25.
- Cancellations made less than 48 hours in advance will be charged a $100 fee. You will also incur this fee if you arrive more than 10 minutes past your scheduled appointment time.
- In the event of a missed appointment without proper notification, the card on file will be charged for the full fee of the appointment. This is $145 for a follow up appointment and $290 for initial appointments.
- You have the right to request an invoice/statement at any time.
- Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness will not be held liable for any fraudulent charges made to the credit card account.
- If you are not the cardholder of the credit card on file, you agree to take full responsibility for any charges made by Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness to the card you have provided.

_____ Date: _____

Printed Name of Patient

_____

Signature of Patient

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Consent to Participate in Treatment by Telemedicine

I understand that telemedicine is different from traditional medicine in that sessions will occur remotely via the HIPAA-compliant video teleconference (VTC) platform Doxy.me or equivalent (e.g. Zoom, Spruce, Virtual Therapy Connect, etc). I am familiar with the technology required for conducting telemedicine sessions and *I will conduct all sessions from a private, well-lit location* (and from my home if required by insurance).

I understand that some benefits of telemedicine include increased access to medical care and my personal convenience. As with any medical procedure, there are potential risks associated with the use of telemedicine/teletherapy. These risks include, but my not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the provider.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

By signing this form, I attest to and understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine/teletherapy, and that no information obtained in the use of telemedicine/teletherapy which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand I have the right to withhold or withdraw my consent to the use of telemedicine/teletherapy in the couse of my care at any time and that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
3. I understand that I may expect the anticipated benefits from the use of telemedicine/teletherapy in my care, but that no results can be guaranteed or assured.
4. I understand that there may be technical limitations associated with receiving treatment via telemedicine; equipment may fail and my doctor may determine at any time that the quality of the connection is not sufficient to continue. I will provide (and will be provided) a backup telephone number to use in case of VTC failure.
5. I understand that the laws that apply to the practice of medicine and to the privacy of healthcare information also apply to telemedicine.

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6. I will notify my medical provider of my exact location and identity prior to and at the onset of each telemedicine session. Due to federal and state laws, healthcare providers are only able to provide services to patients physically located in states in which they are licensed. *Kathryn Werner, PA-C is currently licensed to practice in Alabama and Idaho. As such, patients must be located within the boundaries of these states during the appointments. If a patient presents to an appointment while out of state without sufficient notice, a no-show fee will apply.*
7. I will notify my provider if any other person can hear or see any part of any telemedicine session. It is my responsibility to ensure that my VTC equipment and software are operating properly prior to my appointment.
8. I understand that as a prerequisite for receiving treatment by VTC, I may be required to visit with my family physician or Primary Care Provider (PCP) (and to provide corresponding records) as directed, and/ or to obtain laboratory testing.
9. I understand that even if I am accessing the provider from my own home, my provider may contact police or 911 in the event of a life threatening emergency.
10. *I will not record any VTC session without Kathryn Werner, PA-C's written permission* and I understand that Kathryn Werner, PA-C will not record any session without my written permission.
11. I understand that in compliance with the Ryan Haight Act, controlled substances cannot be prescribed without an in person appointment yearly. *At this time, White Pine Mental Health & Wellness does not provide any in person appointments and therefore will not prescribe any controlled substances.*
12. Payment for and completion of a telemedicine session is not a guarantee of a prescription; prescriptions are offered only under appropriate clinical conditions determined by Kathryn Werner, PA-C. Prescriptions will not be ordered or refilled following a missed appointment.
13. I understand that failure to comply with any of the above may result in immediate treatment termination.

My questions have been answered to my satisfaction. I understand my alternatives to treatment via telemedicine, which may include traditional outpatient appointments with other providers. I understand the risks and benefits of receiving treatment via telemedicine, and I hereby consent to participate in telemedicine. I may revoke this consent at any time. I hereby understand and agree to the above terms & conditions.

My signature below indicates my understanding and approval of the above.

_____ Date: _____

Printed Name of Patient

_____

Signature of Patient

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed as well as your access to it. Protected health information about you is obtained as a record of your visits or contacts with Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness for health care services.

Specifically protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

Kathryn Werner, PA-C PC DBA White Pine Mental Health & Wellness ("The Company" which also infers a provider from The Company) is required by law to maintain the privacy of your health information and to provide you with this Notice of Privacy Practices. The Company will abide by the terms of this Notice of Privacy Practices; notify you if The Company cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you. It describes your rights to access and control your protected health information. It also describes how we follow those rules in the use and disclosure of your protected health information for the purposes of providing treatment, obtaining payment for the services you receive, managing our healthcare operations and for other purposes permitted/required by law.

HOW MEDICAL INFORMATION MAY BE USED

The Company uses medical records as a way of recording health information, planning care and treatment and as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that The Company is required to submit in order to bill for treatment provided to the patient. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of us.

USES AND DISCLOSURES OF INFORMATION

Under federal law, The Company is permitted to use and disclose personal health information without authorization for treatment, payment and health care operation (including but not limited to activities such as communications among health care providers, conducting quality assessment and improvement activities, contracting with insurance companies). Such information may include documenting your symptoms, examination, test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Under most circumstances, The Company will not share your PHI with anyone without your express permission. However, this office is permitted by federal privacy laws to use and disclose your PHI for purposes of treatment, payment, and health care operations.

HOW MEDICAL INFORMATION MAY BE DISCLOSED WITHOUT REQUIRING AUTHORIZATION

In addition to uses and disclosures related to treatment, payment, and health care operations, The Company may also use and disclose your personal information without authorization for the following additional purposes:

- *Abuse, neglect or domestic violence*: As required or permitted by law, The Company may disclose health information about you to a state or federal agency to report suspected abuse, neglect or domestic violence. If such a report is optional, The Company will use its professional judgment in deciding whether or not to make such a report. If feasible, The Company will inform you promptly that such a disclosure has been made.
- *Appointment reminders and Other Health Services:* The Company may disclose your PHI to remind you about an appointment or to inform you about treatment alternatives or other health related benefits and services that may be of interest to you, such as case management or care coordination.
- *Communicable diseases:* To the extent authorized by law, The Company may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.
- *Coroners, medical examiners and funeral directors:* The Company may disclose health information about you to a coroner or medical examiner, for example, to assist in the identification of a decedent or determining cause of death. The Company may also disclose health information to funeral directors to enable them to carry out their duties.
- *Food and Drug Administration:* The Company may disclose your PHI to the FDA or an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.
- *Health oversight:* The Company may disclose your PHI for oversight activities authorized by law or to an authorized health oversight agency to facilitate, auditing, inspection, or investigation related to our provision of health care, or the health care system.
- *Judicial or administrative proceedings:* The Company may disclose your PHI in the course of a judicial or administrative proceeding, in accordance with our legal obligation.

- *Law enforcement:* The Company may disclose your PHI to a law enforcement official for certain law enforcement purposes. For example, The Company may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness or make a report concerning a crime or suspected criminal conduct.
- *Personal representative:* If you are an adult or emancipated minor, The Company may disclose your PHI to a personal representative authorized to act on your behalf in making decisions about your health care.
- *Public health activities:* As required or permitted by law, The Company may disclose your PHI to a public health authority, for example, to report a disease or death.
- *Public safety:* Consistent with our legal and ethical obligations, The Company may disclose your PHI based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.
- *Required by law:* The Company may disclose your PHI as required by federal, state or other applicable law.
- *Specialized government functions:* The Company may disclose your PHI for certain specialized government functions as authorized by law. This includes military command, determination of veteran's benefits, national security and intelligence activities, protection of the President and other officials, and the health, safety and security of correctional institutions.
- *Workers compensation:* The Company may disclose health information about you for purposes related to workers compensation as required and authorized by law.
- *Serious threat:* The Company may disclose your PHI to avert a serious threat to health or safety consistent with applicable law to prevent or lessen a serious imminent threat to the health or safety of a person or the public.
- Other uses and disclosures will be made only with your written authorization and you may revoke that authorization in writing as below (see "your rights").

YOUR RIGHTS UNDER THE PRIVACY RULE

The following is a statement of your rights under the Privacy Rule in reference to your protected health information. Please feel free to discuss any questions or concerns with the staff.

YOUR RIGHTS TO A COPY OF PRIVACY POLICIES

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain. Upon request, you will be provided with a revised Notice of Privacy Policies.

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YOUR RIGHTS TO AUTHORIZE OTHER USE AND DISCLOSURE

This means that you have the right to authorize or deny authorization for any other use/disclosure of protected health information not specified in this notice. You may revoke an authorization at any time except to the extent that Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness has taken an action in reliance on the use or disclosure indicated in the authorization. Any revocation of authorization to use or disclose protected health information must be presented in writing.

YOUR RIGHTS TO DESIGNATE A PERSONAL REPRESENTATIVE

This means that you may designate a person who then has the delegated authority to consent to or authorize the use or disclosure of your protected health information. Any notice of revocation of authorization/designation of a previously named personal representative must be presented in writing.

YOUR RIGHTS TO PROTECTED HEALTH INFORMATION

This means you may inspect and obtain a copy of your PHI that is contained in a "designated record set" for so long as The Company maintains the PHI. A designated record set contains medical and billing records and any other records that we use in making decisions about your healthcare. You may not however, inspect or copy the following records: psychotherapy and psychosocial notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a
a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

YOUR RIGHTS TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means you may ask us to restrict or limit the medical information The Company uses or discloses for the purposes of treatment, payment or healthcare operations. We are not required to agree to a restriction that you may request. The Company will notify you if your request is denied. If The Company agrees to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Privacy Officer (Kathryn Werner, PA-C).

YOUR RIGHT TO RECEIVE COMMUNICATION BY ALTERNATIVE MEANS

The Company will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. The Company will not request an explanation from you as the basis for the request. Requests must be made in writing to our Privacy Officer.

YOUR RIGHT TO REQUEST YOUR PROTECTED HEALTH INFORMATION AMENDED

This means you may request an amendment of PHI about you in a designated record set for as long as I maintain this information. In certain cases, The Company may deny your request for an amendment. If your request is denied, you have the right to file a statement of disagreement with our Privacy Office and the Company may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact our Privacy Officer. Requests for amendment must be in writing.

YOUR RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to request an accounting of certain disclosures of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. The Company is also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period
sought for accounting. The Company is not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years.

YOUR RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE OF PRIVACY PRACTICES

At your request, we will provide a paper copy of this notice.

YOUR RIGHT TO REVOKE AUTHORIZATIONS THAT YOU MADE PREVIOUSLY TO USE OR DISCLOSE INFORMATION

You have the right to revoke any previously made authorizations to use or disclose information. You can accomplish this by delivering a written revocation to our office, except to the extent information or action has already been taken.

YOUR RIGHT TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to me. You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, US Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. The Company cannot and will not make you waive your right to file a complaint as a condition of receiving care or penalize you for filing a complaint.

In order to exercise any of your rights described above, you must submit your request in writing to The Company (with the exception of #8). If you have any questions about your rights, please speak with The Company in person or by phone during normal office hours.

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The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Kathryn Werner, PA-C, PC DBA White Pine Mental Health & Wellness. A copy of this signed, dated document shall be as effective as the original. A current copy of the privacy policy may be found at www.whitepinemhw.com.

_____ Date of Birth: _____

Printed Name of Patient

_____

Signature of Patient or Parent/Legal Guardian (and relationship if patient is a minor)