MONTANA KIDNEY PLLC

Patient's Rights

1. All patients have the right to informed consent in treatment decisions, timely access to specialty care, and confidentiality protections.
   Patients should be treated courteously with dignity and respect. Before consenting to specific care choices, they should receive complete and easily understood information about their condition and treatment options. Patients should be entitled to coverage for qualified second opinions; timely referral and access to needed specialty care and other services; confidentiality of their medical records and communications with providers; and, respect for their legal advanced directives or living wills.
2. All patients have the right to concise and easily understood information about their coverage.
   This information should include the range of covered benefits, required authorizations, and service restrictions or limitations (such as on the use of certain healthcare providers, prescription drugs, and "experimental" treatments). Plans should also be encouraged to provide information assistance through patient ombudsmen knowledgeable about coverage provisions and processes.
3. All patients have the right to know how coverage payment decisions are made and how they can be fairly and openly appealed.
   Patients are entitled to information about how coverage decisions are made, i.e. how "medically necessary" treatment is determined, and how quality assurance is conducted. Patients and their family caregivers should have access to an open, simple, and timely process to appeal negative coverage decisions on tests and treatments they believe to be necessary.
4. All patients have the right to complete and easily understood information about the costs of their coverage and care.
   This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, copayments, and additional premiums), and any catastrophic cost limits. Upon request, patients should be informed of the costs of services they've been rendered and treatment options proposed.
5. All patients have the right to a reasonable choice of healthcare providers and the ability to change providers if dissatisfied with their care. Information should be available on provider credentials and facility accreditation reports, provider expertise relative to specific diseases and disorders, and the criteria used by provider networks to select and retain providers. The latter should include information about whether and how a patient can remain with a provider who leaves or is not part of a plan network.
6. All patients have the right to know what provider incentives or restrictions might influence practice patterns.
   Patients also have the right to know the basis for provider payments, any potential conflicts of interest that may exist, and any financial incentives and clinical rules (e.g., quality assurance procedures, treatment protocols or practice guidelines, and utilization review requirements) that could affect provider practice patterns.

All Patients, To the Extent Capable, Have the Responsibility To:

(It is recognized that patients may suffer significant physical and/or mental conditions that may limit their ability to fulfill these responsibilities.)

1. Pursue healthy lifestyles.
   Patients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.
2. Become knowledgeable about their health plans.
   Patients should read and become familiar with the terms, coverage provisions, rules, and restrictions of their health plans. They should not be hesitant to inquire with appropriate sources when additional information or classification is needed about these matters.
3. Actively participate in decisions about their healthcare.
   Patients should seek, when recommended for their age group, an annual medical examination and be present at all other scheduled healthcare appointments. They should provide accurate information to providers regarding their medical and personal histories, and current symptoms and conditions. They should ask questions of providers to determine the potential risks, benefits, and costs of treatment and accessibility of experimental treatments and clinical trials. Additionally, patients should also seek and read literature about their conditions and weigh all pertinent factors in making informed decisions about their care.
4. Cooperate on mutually accepted courses of treatment.
   Patients should cooperate fully with providers in complying with mutually accepted treatment regimens and regularly reporting on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they are pursuing simultaneously.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

MONTANA KIDNEY PLLC

RELEASE OF MEDICAL RECORDS AUTHORIZATION FORM

Patient Information

Name _____

Date of Birth _____

Phone Number: _____

Address _____

City _____ **State** _____ **ZIP** _____

Recipient of Records

I hereby authorize the release of my medical records **TO:**

Name/Organization Benjamin Lawson / Montana Kidney

Address 3550 Mullin Rd, Suite 103A

City Missoula **State** MT **ZIP** 59808

Phone 406-213-8939 **Fax** 406-224-6127

Information To Be Released

I authorize the release of the following medical Information (check all that apply):

____Complete Medical Record
____Lab Reports
____Imaging/Radiology Reports
____Mental Health Records*
____HIV/AIDS Testing Records
____Drug/Alcohol Treatment Records*
____Other (Please specify)

_____

** May require additional authorization or comply with federal/state-specific confidentiality laws.*

Purpose of Disclosure

I authorize the release of the following medical Information (check all that apply):

____Continuation of Care
____Legal
____Insurance
____Personal Use
____Other (Please specify)
_____

Patient Rights & Acknowledgement

- I understand that I may revoke this authorization at any time in writing
- I understand that revocation does not apply to information already released
- I understand that information disclosed under this authorization may be subject to re-disclosure and my no longer be protected by HIPAA privacy regulations

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CONSENT FOR RELEASE OF MEDICAL INFORMATION
This consent permits the Practice to use and disclose my protected heatlh information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of portected health information is described in the Practice's notice of privacy practices. A patient has the right to review the 'notice' prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hearby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records

Participation in the HIE helps ensure continuity of care by providing a more complete and timely view of your medical history, medications, test results, and treatment plans—regardless of where you receive care.

Signature _____

If signed by a personal representative:

Name _____

Relationship to Patient _____

Legal Authority: POALegal or Guardian/Parent or Other (Please specify)

MONTANA KIDNEY PLLC

Patient Payment Policy

Purpose

This policy outlines the financial responsibilities of patients receiving care at Montana Kidney, PLLC and ensures transparency in the billing and payment process. As a specialty provider, our goal is to provide high-quality nephrology care while maintaining an efficient and fair billing process.

Insurance and Billing

Insurance Verification: We will verify your insurance coverage prior to your visit; however, it is your responsibility to provide accurate and current insurance information. Referrals & Authorizations: Some insurance plans require referrals or prior authorizations. Failure to obtain these may result in claim denial and patient responsibility. Billing: We will bill your primary and, if applicable, secondary insurance as a courtesy. Any remaining balance after insurance is your responsibility.

Copayments, Deductibles, and Coinsurance

Due at Time of Service: All copayments, coinsurance, and deductibles must be paid at the time of service, in accordance with your insurance plan.
Nonpayment: Failure to pay at the time of service may result in your appointment being rescheduled.

Self-Pay Patients

Patients without active insurance coverage are required to pay in full at the time of service unless a prior payment plan has been established.

Accepted Payment Methods

We accept:

- Credit/Debit Cards
- HSA/FSA Cards
- Personal Checks
- Cash
- Online payments via our Patient Payment Portal

Billing Statements & Payment Terms

Statements: Monthly billing statements will be sent for any outstanding balances.
Payment Due: Balances are due within 30 days of the statement date.

Returned Checks

A $25.00 fee will be charged for any returned checks.
Future payments may be required in certified funds or by credit card.

Outstanding Balances & Collections

Accounts unpaid after 90 days and without an active payment plan may result in further collection activity. Patients may be discharged from the practice for repeated nonpayment.

Medicare & Medicaid Patients

We accept Medicare and Medicaid and follow all applicable billing regulations. Patients are responsible for any services not covered by Medicare/Medicaid.

Questions and Contact Information

For questions about your bill or to discuss payment options, contact our billing office:

- Phone:
- Email:
- Office Hours:

Acknowledgment of Patient Payment Policy

I have received and read the Patient Payment Policy for Montana Kidney, PLLC. I understand and agree to the terms outlined above.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

MONTANA KIDNEY PLLC

NOTICE OF PATIENT'S PRIVACY RIGHTS

The Notice of Privacy Practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this Practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Please Review This Notice Carefully

1. Our commitment to your privacy:
   Our Practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our Practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Patient's Privacy Rights currently in use by the Practice.
   We realize that these laws are complicated, but we must provide you with the following important information:
   - How we may use and disclose your PHI;
   - Your privacy rights in your PHI; and
   - Our obligations concerning the use and disclosure of your PHI.

   The terms of this Notice apply to all records containing your PHI that are created or retained by our Practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will apply to all of your records that our Practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our Practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time. Our Practice will always follow the Notice that is in effect at the time any action related to PHI is taken.

2. If you have questions about this Notice, please contact:
3. Manager: 406-213-8939 or Privacy and Security Officer
4. The different ways in which we may use and disclose your PHI.
   The following categories describe the different ways in which we may use and disclose your PHI:
   - **Treatment.** Our Practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of

the people who work for our Practice including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, with your authorization, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents, collectively called your ?Friends and Family List? as documented by you on your Patient Authorization for Use and Disclosure of Protected Health Information? form. To let us know with whom you want your information shared, please be sure to complete this notice. Anytime you would like to update your Friends and Family List, please contact the office. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

- **Payment.** Our Practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts. You have the right to request that our Practice not submit a claim to your insurance company for payment due to privacy concerns. However, you agree to pay for all services in full under the time frame specified by our Practice. Failure to do so constitutes a waiver of this right (see ?Requesting Restrictions? below).
- **Healthcare Operations.** Our Practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our Practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our Practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.
- **Appointment Reminders.** Our Practice may use and disclose your PHI to contact you and remind you of an appointment.
- **Treatment Options.** Our Practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
- **Health-Related Benefits and Services.** Our Practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
- **Release of Information to Family and Friends.** With your authorization, our Practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians? office for treatment of a cold. In this example, the babysitter may have access to this child?s medical information since they brought the child to the appointment and were present during the examination. Generally, we require written authorization to share your PHI with friends and family members.
- **Disclosures Required by Law.** Our Practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

5. Use and disclosure of your PHI in certain special circumstances:
   The following categories describe unique scenarios in which we may use or disclose your PHI:
   Public Health Risks. Our Practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths;
   - Reporting child abuse or neglect;
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition;
   - Reporting reactions to drugs or problems with products or devices;
   - Notifying individuals if a medication, product or device they may be using has been recalled;
   - Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only

disclose this information if the patient agrees or we are required or authorized by law to disclose this information; or

- Notifying your employer under limited circumstances related primarily to work- place injury or illness or medical surveillance.

Health Oversight Activities. Our Practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the healthcare system in general.
Lawsuits and Similar Proceedings. Our Practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person?s agreement;
- Concerning a death we believe has resulted from criminal conduct;
- Regarding criminal conduct at our offices;
- In response to a warrant, summons, court order, subpoena, or similar legal process;
- To identify/locate a suspect, material witness, fugitive, or missing person; and
- In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity, or location of the perpetrator).

Deceased Patients. Our Practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
Organ and Tissue Donation. Our Practice may release your PHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
Research. Our Practice may use and disclose your PHI for research purposes in certain limited circumstances, most often when your information is de-identified in such a way that it cannot be attributed to you. We will obtain written authorization to use your PHI for research purposes except when the Practice?s Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

14. The use or disclosure involves no more than a minimal risk to your privacy based on the following:
    a. An adequate plan to protect the identifiers from improper use and disclosure;
    b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
    c. Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the re- search study, or for other research for which the use or disclosure would otherwise be permitted.
15. The research could not practicably be conducted without the waiver.
16. The research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety. Our Practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. OOur Practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
National Security. Our Practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.
Inmates. Our Practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.
Workers? Compensation. Our Practice may release your PHI for Workers? Compensation and similar programs.

6. Your rights regarding your PHI:
   You have the following rights regarding the PHI that we maintain about you:
   Confidential Communication. You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Manager at 406-213-8939 specifying the requested method of contact and/or the location where you wish to be contacted. Our Practice will accommodate reasonable requests. You do not need to give a reason for your request.
   Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Manager at 406-213-8939. Your request must be describe in a clear and concise fashion.
   - The information you wish restricted;
   - Whether you are requesting to limit our Practice?s use, disclosure, or both; and
   - To whom you want the limits to apply.

   Inspection and Copies. You have the right to view, download and/or transmit to a third party online the PHI that may be used to make decisions about you, including your medical records and billing records, but not including psychotherapy notes. You must register with the Practice?s patient portal or submit your request in writing to the manager in order to inspect and/or obtain a copy of your PHI. If applicable, our Practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request.
   Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our Practice. To request an amendment, your request must be made in writing and submitted to the manager You must provide us with a reason that supports your request for amendment. Our Practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (1) accurate and correct; (2) not part of the PHI kept by or for the Practice; (3) not part of the PHI that you would be permitted to inspect; or (4) not created by our Practice, unless the individual or entity that created the information is not available to amend the information.
   Accounting of Disclosures. All of our patients have the right to request an ?accounting of disclosures.? An ?accounting of disclosures? is a list of certain non-routine disclosures our Practice has made of your PHI. To obtain an accounting of disclosures, you must submit your request in writing to the manager. All requests for an ?accounting of disclosures? must state a time period, which may not be longer than six years from the date of disclosure. The first list you

request within a 12-month period is free of charge, but our Practice may charge you for additional lists within the same 12-month period. Our Practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the manager.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our Practice, contact the manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our Practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. If you have any questions regarding that this Notice or our health information privacy policies, please contact the manager.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____ , have received a copy of the Notice of Privacy Practices.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____