Laurel Fertility Care
GROWING DREAMS TOGETHER

Patient Bill of Rights

All patients seeking care at Laurel Fertility Care have the right to:

1. Accurate information as to their diagnosis and various treatment options. The guiding principle of treatment is informed consent which is interpreted to mean a full understanding, prior to treatment selection, of the efficacy, discomforts, inconveniences, risks and costs of each treatment choice.

2. A second opinion regarding diagnosis and/or treatment from any other fertility center of their choice. You will be informed if the physician has a financial interest in the facility to which you are being referred

3. Medical diagnosis and treatment that meets or exceeds the community and national standard of care.

4. Courteous interactions with all Laurel Fertility Care medical, nursing and administrative staff members.

5. Privacy during examinations and consultations.

6. Confidentiality of all records pertaining to all aspects of their care at Laurel Fertility Care.

7. A clean, safe and comfortable medical facility.

8. Referral to competent specialists in other medical disciplines when necessary.

9. A copy or accurate summary of their care while patients at Laurel Fertility Care, upon their written request.

10. An understanding that in spite of all of the above, a successful pregnancy cannot be promised or guaranteed, no matter what the clinical situation or treatment choice.

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.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. All of the ways we are permitted to use and disclose your health information fall within one of these categories.

TREATMENT. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example - we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

PAYMENT. We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example — we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

HEALTH CARE OPERATIONS. We will use and disclose your protected health information to support the business activities of our practice. For example -- we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription, or other services for our practice.

OTHER WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

APPOINTMENT REMINDERS. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

TREATMENT ALTERNATIVES. We will use and disclose your protected health information to tell you about or recommend possible alternative treatments or options that may be of interest to you.

OTHERS INVOLVED IN YOUR CARE. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

RESEARCH. We will use and disclose your protected health information to researchers, provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

AS REQUIRED BY LAW. We will use and disclose your protected health information when required to by federal, state, or local law.

TO AVERT A SERIOUS THREAT TO PUBLIC HEALTH OR SAFETY. We will use and disclose your protected health information to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your

health information to a foreign government agency that is collaborating with the public health authority.

WORKER'S COMPENSATION. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the practitioner or facility that compiled it, the information belongs to you. You have the right to:

A PAPER COPY OF THIS NOTICE. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

INSPECT AND COPY. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer: Attention: Privacy Officer, Laurel Fertility Care, 1700 California Street, Suite 570, San Francisco, CA, 94109, Phone: (415) 673-9199. You may send your request by regular mail, electronic mail, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

REQUEST AMENDMENT. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment.

- The information is not part of the record which you are permitted to inspect and copy.

- The information is not part of the designated record set kept by this practice or if it is the opinion of the opinion of the health care provider that the information is accurate and complete.

REQUEST RESTRICTIONS. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example - you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.
We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. If we do agree, we will comply with your request except for emergency treatment.

AN ACCOUNTING OF DISCLOSURES. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. You request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal

obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an addition list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request how we communicate with you to preserve your privacy. For example - you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

FILE A COMPLAINT. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice or directly to:

Office for Civil Rights
Department of Health and Human Services
Attn: Patient Safety Act 200 Independence
Ave., SW, Rm. 509F Washington, DC 20201

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer.

USES OR DISCLOSURES NOT COVERED

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

FOR MORE INFORMATION

If you have questions or would like additional information, you may contact our Privacy Officer: Carol Williams, at Carol@laurelfertility.com or 415.673.9199

Effective Date - April 14, 2003

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. Laurel Fertility Care provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, coordination of care with independent agencies, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

This Consent was signed by: _____

Patient:

This Consent was signed by:

Partner : _____

Witness: _____ Date:

Printed name - Practice representative:

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PLEASE READ AND INITIAL

☐ I am financially responsible for services provided to me or my dependent by Laurel Fertility Care.

☐ If at a later date I am able to show proof of contracted insurance coverage and/or written authorization for services rendered, Laurel Fertility Care will take necessary steps to provide my insurance carrier with information, but I am ultimately responsible for all charges.

☐ Services provided at Laurel Fertility Care that are not authorized or covered by my primary insurance are my responsibility.

☐ I authorize release of information to my insurance company.

☐ I understand the diagnosis code WILL NOT be changed after a claim has been submitted to my insurance company.

☐ I understand that I AM RESPONSIBLE FOR UNDERSTANDING WHAT MY INSURANCE COVERS.

☐ I understand that my insurance may not pay for office visits, ultrasounds, labs, or medications that are considered "infertility".

☐ I understand that I will be charged $40.00 if I "NO SHOW" for an appointment.

Patient Name: _____ Signature: _____ Date: _____

Partner Name: _____ Signature: _____ Date: _____