WellServe Health, Inc.
Notice of Privacy Practices
Effective 03/01/2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WellServe Duties.

As a covered entity, WellServe Health, Inc. will fulfill the needs of its consumers; to protect them in a way consistent with the mission statement and the ethical standards WellServe consequently holds itself to. Its goal is to create a balanced risk management and governance program that is adaptive to the country's ever changing patterns of care, in a way that continuously protects individuals from any harm or inconvenience to their mental, physical or otherwise overall health. WellServe's mission is to assist it's consumers in any way it can, which includes its policy of first do no harm.

WellServe believes that if the individual is respectfully involved with complete awareness to their rights regarding their PHI, a better system is created with checks and balances for a more complete system of protection. WellServe understands all aspects of PHI and systematically addresses its use and disclosure in order to avoid the failure of information protection. WellServe believes protected health information is a privilege and symbol of trust with its consumers; it is of utmost importance to prevent irresponsible use of it.

WellServe is required by law to provide this notice which describes the privacy practices of all staff members authorized to receive information about you. This includes all individuals associated with WellServe, staff, volunteers, independent contractors and workforce members. WellServe is required to abide by the terms of this notice the moment of its effective date. WellServe does reserve the right to change the terms in this notice. It will inform all concerned individuals of material changes with a revised notice. WellServe will make sure that your medical information is protected under law and follow the terms of the notice that is currently in effect.

How WellServe may use and disclose your protected health information (PHI).

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Payment.

RELEASE OF INFORMATION: I hereby authorize WellServe Health, Inc. (hereinafter referred to as "Provider") to disclose by telephone, facsimile, electronic data interchange, or by document deliver by carrier or postal service, any part of my service record for payment purposes, including but not limited to Provider's billing service, any governmental agencies; insurance carrier, or others who are financially liable for my support care, including but not limited to, case management, county of legal settlement, State of Iowa, Title XIX, or Medicare, all information needed to substantiate payment for such support service care, and to permit representatives thereof to examine and make copies of all records relating to such support and treatment.

For Treatment.

Provider may also disclose by telephone, facsimile, electronic data interchange, or by document delivery by carrier or postal service all or any part of my service records for treatment purposes, including but not limited to any Health Care Provider documented within the medical record, partners of treating Health Care Providers, on-call Health Care Providers, consultants utilized by any Health Care Provider of record, pharmacist and pharmacy staff: those employed by provider, Provider's answering service, or to any human service agency that I am transferred to for continuance of care, including the ambulance service which transfers me. I also agree that I may give verbal authorization to release my service record for the provider to resolve issues with my associates, health care providers, housing provider, or potential housing provider. I agree now that a verbal authorization is an acceptable means to authorize release of information.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

For Health Care Operations.

I also authorize Provider to use and disclose all or any part of my service record for its human service operations which include, but are not limited to, the management and administration of Provider, Provider quality assurance and peer review activities, auditing, credentialing or general business purposes. I give my permission to Provider to unblock their telephone when calling my home, which may cause Provider's Name and/or phone number to appear on caller identification box if one is owned, and Provider may leave a message on my answering machine or in my voice mail or text me.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or

more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information. Additionally, this is done only on an as needed basis.

Other uses and disclosures of PHI.

HEALTH AND HUMAN SERVICES: I understand that parts of my support service record, including psychotherapy notes, may also be released as required by law or by the Human Services to investigate the Provider's compliance with federal privacy laws or as permitted by law for health oversight activities, for activities of coroners and medical examiners, or as necessary to prevent or lessen a serious and imminent threat to the health or safety of another person, the public, or myself. I understand that parts of my support service record, including psychotherapy notes, may also be released as required by law or the Iowa Department of human services, to a State or County government agency.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

• Any purpose required by law;
• Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
• If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
• To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
• To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
• Court or administrative ordered subpoena or discovery request;
• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
• To coroners and/or funeral directors consistent with law;
• If necessary to arrange an organ or tissue donation from you or a transplant for you;
• If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
• To workers' compensation agencies for workers' compensation benefit determination.

Your Individual Rights.

RIGHT TO RESTRICT DISCLOSURES: I understand that I have the right to revoke this consent at any time in writing. I also understand that any revocation by me of this consent will only apply to future uses and disclosures and such revocation must be in writing.

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the

protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or our legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid [Practice Name] in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Current information on filling complaints can be found at: https://www.hhs.gov/ocr

The nearest regional office for Iowa is:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact WellServe and as for the Privacy Officer by phone at 515-461-9316 or at the following address: 6200 Aurora Ave, Suite 307E, Urbandale, IA 50322.
This Notice of Privacy Practices is also available on our web page at www.wellserve.health.