Welcome to
Delta Health and Wellness!

Welcome to Delta Health and Wellness! I am so glad that you have entrusted me with your medical care and hope that you have a positive experience with the practice. I am excited to get to know you and assist you with your health journey.

One of the foundations of a direct primary care practice is providing accessible communication regarding your health care. I aim to be available when you need me and phone calls will be forwarded to my cell phone after-hours and on weekends for urgent needs. There are no answering services or complicated phone trees. I also hope that you find other benefits of being a patient of Delta Health and Wellness, such as discounted pricing on generic prescription medications and laboratory studies. I am also looking forward to expanding service offerings as we grow in order to provide comprehensive, quality primary care services for you.

Attached you will find the patient enrollment packet. Please carefully read the Patient Agreement, Services Guide, Patient Enrollment Form, Contract for Services Provided to Medicare Beneficiaries (if applicable), Telemedicine Informed Consent, and Notice of Privacy Practices. Do not hesitate to reach out with any questions or for clarification. During the online registration process, you will electronically agree to these terms and conditions. After your online registration is complete, I will be in touch shortly to arrange your first patient appointment. In the meantime, you may complete the Authorization to Release Healthcare Information and provide this form to your current healthcare provider to fax your medical records to Delta Health and Wellness. For your initial visit, please bring a list of your medications and any health records that you may have so that we can get to know you better. Having contact information for previous doctors will help us request any other prior records that may be important to continuity of care.

Our office strives to be paperless and we will not routinely keep paper records in the office. Any forms you complete will be scanned into your HIPAA-compliant electronic medical record. We will not keep any of your financial data in the clinic, either - it gets encrypted into our billing software.

Please note that you will not be able to receive any care over the phone, or via text or email, until you have your first in-person appointment.

I look forward to meeting you!
Dr. Stacey Kuhfahl

Delta Health and Wellness
Patient Agreement

Updated 11/21/2024

Decision to join: I acknowledge and understand that I am voluntarily becoming a Delta Health and Wellness patient, as offered by Delta Health and Wellness Inc, and that this agreement is non-transferable. The effective date of my Delta Health and Wellness Patient Agreement is the date on which I sign this agreement. I have reviewed the Delta Health and Wellness Services Guide and I have had the opportunity to ask questions and receive answers regarding its content.

Fee schedule: I acknowledge and understand the following Delta Health and Wellness services fee schedule:

$100 one-time nonrefundable enrollment fee

18 to 49 years	$100 per month
50 to 99 years	$125 per month
100+ years	$1 per month

Charge responsibility: I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside the physical location of Delta Health and Wellness, including, but not limited to, emergency room visits, hospital and specialist care, and imaging and laboratory tests performed by third parties. Additionally, I acknowledge and understand that I am responsible for any charges incurred for health care services provided by Delta Health and Wellness but not specifically described in the Delta Health and Wellness Services Guide.

Billing: The one-time nonrefundable enrollment fee is due upon execution of this agreement. After paying my enrollment fee, I acknowledge and agree to pay my monthly care fee(s) on or before the due date. Monthly fees will begin on the date of the first visit (which will be prorated to the first of the month), in the amount as described in the fee schedule. Thereafter, the membership fee will be due on the first day of every month. This payment will cover the following month's services fee. Any additional labs and medications will be charged at the time of service and payment in full is expected at that time. In the event I am unable to pay my fee(s) on time, I understand I will be charged a $30 late fee and that this agreement may be terminated. I agree that the required method of payment for monthly membership fees will be by automated payment through automatic bank draft (ACH) or credit/debit card. Any incidental charges including prescriptions, laboratory studies, durable medical equipment, etc. will be due at the time of service and payment for these items can be made by automatic bank draft (ACH), credit/debit card, or personal check. For safety purposes, no cash will be accepted or kept in the office.

Medicare: I understand that Dr. Stacey Kuhfahl has opted out of Medicare. As a result, both I and Dr. Stacey Kuhfahl shall be prohibited by law from seeking reimbursement from Medicare for any services provided under this agreement. Accordingly, I agree not to submit bills or seek reimbursement from Medicare for any such services. Furthermore, if I am eligible or become eligible for Medicare during the

term of this agreement, I agree to immediately inform Dr. Stacey Kuhfahl and sign the Medicare private contract as provided and required by law.

DELTA HEALTH AND WELLNESS IS NOT INSURANCE: I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage, nor is it a contract of insurance, and that it provides only the health care services specifically described in the Delta Health and Wellness Services Guide. If a service is not specifically listed in the Delta Health and Wellness Services Guide, it is expressly excluded from this agreement. Delta Health and Wellness will not bill insurance carriers or any third-party payors on my behalf for any services specifically described in the Delta Health and Wellness Services Guide. If I wish to seek reimbursement, I understand that Delta Health and Wellness will not provide administrative support for these matters. It is highly recommended to maintain health insurance for unpredictable and catastrophic expenses.

Quitting the practice: I acknowledge and understand that both Delta Health and Wellness and I have the absolute and unconditional right to terminate this agreement, without the showing of any cause for termination. I may terminate my agreement with Delta Health and Wellness at any time and for any reason by providing written notice to Delta Health and Wellness, and the agreement will terminate at the end of the current payment month. Delta Health and Wellness will not terminate this agreement solely based on health status. Delta Health and Wellness will assist in transferring records and care to the new primary care physician designated by the patient. Any payments outstanding through the date of termination of the agreement are the responsibility of the patient.

Rejoining: I acknowledge and understand that if I terminate my Delta Health and Wellness Patient Agreement after receiving initial services, I may be allowed to reestablish my enrolled patient status only after payment of the rejoining fee of $375. I acknowledge and understand that Delta Health and Wellness is not obligated to allow me to reenroll if I have previously terminated my agreement.

Controlled substance policy: No controlled substances will be stored in the office. Additionally, Dr. Kuhfahl does not believe in routinely prescribing controlled substances, such as benzodiazepines and narcotics/opioids. She believes that most chronic pain requiring narcotics is best managed by a Pain Management specialist. However, she is happy to work with you on other options to manage your pain and other medical conditions including non-controlled substance medications, stress/anxiety management, sleep hygiene, etc.

Out of office policy: At Delta Health and Wellness we can take care of most people, most of the time, and we try to be available for our patients when they need us. On occasion, Dr. Kuhfahl will be out of the office. It is conceivable that some years Dr. Kuhfahl may take up to a total of 4 weeks of vacation, with ample notice provided to patients. Whenever possible, she will remain accessible via phone, though response times may be delayed. Most cases can be handled over the phone but on the rare occasion a patient needs to be seen, patients may be directed to another medical provider at his or her own expense.

Change in service: I acknowledge and understand that Delta Health and Wellness may add or discontinue services, or may increase my fee schedule at any time (but no more than once per year) and that I will be given written notice at least sixty (60) days in advance of such fee schedule changes. If I do

not consent to the modification, I may terminate the Agreement in writing prior to the next scheduled monthly payment.

Privacy of communications: I acknowledge that Delta Health and Wellness will comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy requirements. I also understand that communications with the physician using e-mail, facsimile, video chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communication. I further acknowledge that all such communications may become part of the electronic medical record. By providing an e-mail address upon registration, I authorize Delta Health and Wellness and its physicians to communicate with me by e-mail regarding my "protected health information" (PHI). By providing a cell phone number on the Patient Enrollment Form and checking the "YES" box on the corresponding consent question, I consent to text message communications containing PHI through the number provided. I further understand and acknowledge that e-mail and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access. I also understand that email and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. Therefore, in an emergency or a situation that could reasonably be expected to develop into an emergency, I agree to call 911 or go to the nearest emergency care facility.

Addressing concerns: I agree to bring any complaints about services I receive as a Delta Health and Wellness patient to the attention of Dr. Kuhfahl to be addressed as quickly and completely as possible. I acknowledge that Delta Health and Wellness strives for excellent customer service and would like to know if something is not right.

Severability: If for any reason any provision of this agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

Jurisdiction: This agreement shall be governed and construed under the laws of the State of Delaware and all disputes arising out of the agreement shall be settled in the court of proper venue and jurisdiction for 17021 Old Orchard Road Unit 4 in Lewes, Delaware.

By signing below, I agree to the terms of this agreement. The agreement will commence on the date it is signed by the patient and the physician below and will extend monthly thereafter.

Accepted and agreed upon by:

_____

Patient name

_____

Patient (or Guardian) signature

Date: _____

Delta Health and Wellness

_____

Stacey Kuhfahl, DO
17021 Old Orchard Rd, Unit 4
Lewes, DE 19958

Date: _____

A. INCLUDED SERVICES

1. Wellness visits
    - Annual wellness/physical examinations
    - School, sports, and camp physicals (including form completion)
    - Healthy lifestyle and eating counseling
    - Weight loss planning
    - Stress management
    - Fitness counseling
    - Smoking cessation
    - Vision screening
    - Hearing screening
    - Cancer screening
    - National Registry of Certified Medical Examiners physical examinations (commonly known as DOT/Department of Transportation physicals)
2. Visits due to illness or injury
    - Sick visits and follow-up visits
    - Orthopedic services (strains, sprains, soft tissue injuries)
    - Treatment of rashes and other skin disorders
    - Simple laceration repair
    - Minor burns treatment
    - Incision and drainage of abscesses
    - Cryotherapy for removal of warts and other skin lesions
    - Skin tag removal
3. Chronic disease management
    - Diabetes
    - High blood pressure
    - High cholesterol
    - Thyroid disorders
    - Asthma & COPD
    - Allergies and eczema
    - Migraines
    - Depression
4. In-office testing
    - Fingerstick glucose testing

- Simple urinalysis
- Rapid Strep testing
- COVID and Flu testing
- Urine pregnancy testing
- Hemoccult (testing for blood in stool)

5. Diagnostic testing
    - EKG with interpretation
    - Pulse oximetry
    - Peak flow meter
6. Procedures
    - Abscess incision and drainage
    - Ear wax removal
    - Wart freezing
    - Simple sutures
    - Basic wound care
    - Joint injections*
    - Joint aspiration (removing fluid from a joint)***
    - Skin biopsy***

*Patient is responsible for the cost of injected medications

***Patient is responsible for all fees associated with pathology and specimen analysis/culture

B. SERVICES AVAILABLE AT ADDITIONAL CHARGE TO MONTHLY SERVICE CHARGE

1. Vaccines
    - Vaccines/immunizations are not routinely stocked, but may be ordered
2. Laboratory testing
    - Laboratory testing including common blood tests, wound culture, urine culture, STD testing, and skin biopsy pathology are available through a local laboratory at negotiated rates
    - Patient is responsible for all fees associated with laboratory testing
    - A draw charge may be required by the laboratory in addition to the negotiated rates
3. Medication dispensary for common non-controlled, generic medications
    - Medications available at wholesale prices
    - Medications not in stock may be ordered
4. Durable medical equipment
    - Equipment such as nebulizers, crutches, wrist splints, knee braces, and arm slings are available to be ordered at wholesale cost

C. EXCLUDED SERVICES

Healthcare services received outside of Delta Health and Wellness, including but not limited to, emergency room visits, urgent care visits, hospital and specialist care, and imaging and laboratory tests performed by third parties not prearranged with Delta Health and Wellness are not included with the monthly charge.

How is Delta Health and Wellness different from other primary care practices?

- Same-day and next business day office appointments, Monday through Thursday excluding holidays
- After hours and weekend visits by appointment, based on availability
- More time spent with the physician, up to 2-hour initial visit with 30-minute follow-up visits as needed
- One-hour long annual wellness exam
- Care when you need it: appointments at your convenience, when appropriate
- Communicate directly with your physician via text, email, video, and phone services
- Labs and radiology with transparent prices
- Many in-office tests included with monthly service charges
- Prescription medications filled in the office at wholesale prices with savings passed directly to the patient
- Laboratory and radiology test results communicated to you clearly, with explanations and recommendations in plain language
- Routine or simple issues may be safely handled through phone, text messaging, or email, saving you time when office visits aren't necessary
- Increased access to your physician, reducing need for urgent care or ER visits
- No scheduling fees or co-pays
- No obligation: you may cancel your contract with Delta Health and Wellness at any time (although we don't think you'll want to!)

Delta Health and Wellness
Patient Enrollment Form

Updated 11/21/2024

Check YES where indicated *only* if you agree to text message communication.

Provide email address *only* if you agree to email communication.

The fees as set in the Fee Schedule shall apply to the following patient, who by signing below (or as legal representative), certifies that they have read and agree to the terms and conditions of this agreement:

Print Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Cell Phone: _____ Alternate Number: _____

Email address: _____

I Agree to Text Communication: (check one below)

- ☐ Yes
- ☐ No

Patient (or Guardian) signature: _____

Printed Name: _____ Relationship to Patient: _____

Delta Health and Wellness Authorization to Release Healthcare Information

Updated 11/21/2024

Patient's Name: _____

Date of Birth: _____

Previous Name, if applicable: _____

Address: _____

I request and authorize to release healthcare information of the patient named above to:

Stacey Kuhfahl, DO
Delta Health and Wellness
17021 Old Orchard Road, Unit 4
Lewes, DE 19958
Phone: 302-329-8712
Fax: 302-481-1330

This request and authorization applies to:

[__] Healthcare information relating to the following treatment, condition, or dates:

_____

[__] All healthcare information

[__] Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

Yes [__] No [__] I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
Yes [__] No [__] I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Delta Health and Wellness
Contract for Services Provided to Medicare Beneficiaries

Updated 11/21/2024

This agreement is between **Stacey M. Kuhfahl, DO** ("Physician"), whose principal place of business is **Delta Health and Wellness (17021 Old Orchard Rd, Unit 4, Lewes, DE 19958)**, and _____ ("Beneficiary"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B.

(a) Physician has informed Beneficiary that Physician has opted out of the Medicare program effective on **January 8, 2024** for a period of at least two years.

(b) Physician is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

(c) Beneficiary or his or her legal representative accepts full responsibility for payment of Physician's charge for all services furnished by Physician, including applicable taxes on such services.

(d) Beneficiary or his or her legal representative understands that Medicare limits do not apply to what Physician may charge for items or services furnished by Physician.

(e) Beneficiary or his or her legal representative agrees not to submit a claim to Medicare or to ask Physician to submit a claim to Medicare.

(f) Beneficiary or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

(g) Beneficiary or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

(h) The effective date of Physician's opt-out of Medicare is **January 8, 2024**, and the opt-out period is anticipated to be indefinite.

(i) Beneficiary or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

(j) This contract was not entered into by Beneficiary or by Beneficiary's legal representative during a time when Beneficiary requires emergency care services or urgent care services.

(k) Physician has provided a photocopy of this Contract to Beneficiary or to his or her legal representative before items or services were furnished to Beneficiary under the terms of this contract.

I have read and agree to all provisions of the above Contract.

"Beneficiary": _____ Date: _____

"Physician": _____ Date: _____

Delta Health and Wellness
Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   I may revoke my right at any time by contacting Delta Health and Wellness at 302-329-8712.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
7. I understand that I will be responsible for any out-of-pocket costs such as prescribed medications or ordered laboratory studies or imaging that apply to my telemedicine visit.
8. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Delaware and will be in Delaware during my telemedicine visit(s).

_____
Patient name

_____
Patient (or Guardian) signature

Date: _____

Delta Health and Wellness
Notice of Privacy Practices

As 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 (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). 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 are also 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 IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- how we may use and disclose your IIHI
- your privacy rights in your IIHI
- our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI 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 be effective for 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 office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Delta Health and Wellness, Inc.
Attn: Privacy Officer
17021 Old Orchard Road, Unit 4
Lewes, DE 19958
(302) 329-8712

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI, unless you object:

1. **Treatment.** Our practice may use your IIHI 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 IIHI in order to write a prescription for you, or we might disclose your IIHI 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 medical assistants—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as other healthcare providers, your spouse, your children or your parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your IHII to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, to develop protocols and clinical guidelines, to develop training programs, and to aid in credentialing, medical review, legal services and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI 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 pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.
9. **Business Associates.** There are some services provided through contracts with "business associates," such as accounting, legal representation, consulting, medical services, etc. When these services are contracted, we may disclose your IIHI to our business associates so that they can perform the job we have asked them to do and, if applicable, bill you or your third-party payer for services rendered. If we disclose protect health information to a business associate, we will do so subject to a contract that provides that the information will be kept confidential.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI 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
    - preventing or controlling disease, injury, or disability
    - notifying a person regarding potential exposure to a communicable disease
    - 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 product or device they may be using has been recalled

- notifying appropriate government 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
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your IIHI 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 health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI 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.
4. **Law Enforcement.** We may release IIHI 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
    - 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)
5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.
6. **Organ and Tissue Donation.** Our practice may release your IIHI 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.
7. **Research**. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.
8. **Serious Threats to Health or Safety**. Our practice may use and disclose your IIHI 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.
9. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security**. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your IIHI 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: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

The following uses and disclosures will require your authorization:

1. **Highly Confidential Information:** Federal and State laws require special privacy protections for certain highly confidential information. We will not disclose your medical information 1) maintained in psychotherapy notes; 2) related to mental health treatment, developmental disabilities services, and drug and alcohol abuse treatment; 3) related to HIV status, testing, and treatment as well as any information related to the diagnosis and treatment of sexually transmitted diseases; and 4) genetic information, without, in each case, obtaining your authorization unless otherwise permitted or required by applicable Federal or State law.
2. **Other Uses or Disclosures Requiring Your Specific Authorization:** Other types of uses and disclosures of IIHI not identified in this notice will be made only with your written authorization. Except as permitted under this Notice or as permitted by law, we will request your written authorization before using or sharing your information for marketing purposes or selling your information. Your authorization may be revoked, in writing, at any time. However, should you revoke such an authorization, you should understand that we are unable to retract any disclosures we have already made with your permission, and that we are required to retain our records as proof of the care that we provided you.

F. YOUR RIGHTS REGARDING YOUR IIHI:

The health and billing records we maintain are the physical property of Delta Health and Wellness. The information in it, however, belongs to you. You have a right to:

1. **Confidential Communications.** 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 Privacy Officer, specifying the requested method of contact, 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.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI 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 IIHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:
    (a) the information you wish restricted;
    (b) whether you are requesting to limit our practice's use, disclosure or both; and
    (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer at Delta Health and Wellness, 17021 Old Orchard Road, Suite 4, Lewes, DE 19958, in order to inspect and/or obtain a copy of your IIHI. Your request should specifically state what medical information you want to inspect or copy. We will ordinarily act on your request within thirty (30) days of our receipt of your request. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us who did not participate in the original decision to deny access will conduct reviews. We will ordinarily act on your request for review within thirty (30) days.
4. **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 Privacy Officer at Delta Health and Wellness, 17021 Old Orchard Road, Suite 4, Lewes, DE 19958. We will ordinarily act on our amendment request within sixty (60) days after our receipt of your request. You must provide us with a reason that supports your request for amendment. If we grant the request, we will inform you of such acceptance in writing. We will make the appropriate amendment to your IIHI, and we will request that you identify and agree that we may notify all relevant persons with whom the amendment should be shared. 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: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created is not available to amend the information.
5. **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 nonroutine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer at Delta Health and Wellness, 17021 Old Orchard Road, Suite 4, Lewes, DE 19958. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) 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 the costs involved with additional requests, and you may withdraw your request before you incur any costs. We will ordinarily act on your accounting request within sixty (60) days of your request. We are permitted to extend our response time for a period of up to thirty (30) days if we notify you of the extension. We may temporarily suspend your right to receive an accounting of disclosures of your health information, if required to do so by law.
6. **Right to Breach Notification:** You have a right to receive written notification when a breach (as defined by HIPAA) of your IIHI has occurred. You will receive notification no later than sixty (60) days after the breach has been discovered.
7. **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 Privacy Officer.
8. **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:

Delta Health and Wellness, Inc.
Attn: Privacy Officer
17021 Old Orchard Road, Unit 4
Lewes, DE 19958

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

9. **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 IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have questions regarding this notice or our health information privacy policies, please contact the Privacy Officer listed above.

Acknowledgement

I hereby acknowledge that I have received and read the Delta Health and Wellness Notice of Privacy Practices. I understand that I may request additional copies of this notice at any time.

Patient Printed Name: _____ Date: _____

Patient Signature: _____