Welcome to Ease-e Medical!

To open your file and process your medical supply orders without delay, please review and return the paperwork along with the requested documentation outlined below.

1. Required Forms & Signatures

- **New Client Paperwork:** Please fill out all attached client details completely.
- **Change of Provider Form:** Ensure this form is fully **signed and dated**. In the "Previous Provider" section, please select the option below that best fits your situation:
    - **A)** If this is a new condition and the supplies were never needed before, please write: **"New condition"**
    - **B)** If you previously purchased supplies at a retail store, please write: **"Paid out of pocket at [insert store name]"** (e.g., Walmart, Amazon)
    - **C)** If you previously received supplies from another DME company, please provide the **company name** and the **date of your last order** from them.
    - **D)** If you are a returning customer to Ease-e Medical and did not use another supplier while away, please write: **"Returning customer- inactive- no other DME supplier used"**

2. Medical Documentation & Prescriptions

Please have your doctor provide a prescription and corresponding chart notes for the specific supply categories you require:

- **Compression Stockings:** Requires a prescription, clinical chart notes, specific compression pressure levels (e.g., 15-20 mmHg, 20-30 mmHg), and physical measurements (ankle, calf, etc.).
- **Enteral Feeding Supplies (Excluding Pumps):** Requires a prescription, clinical chart notes, and a signed Letter of Medical Necessity (LMN).
- **Incontinence Supplies:** Requires a prescription, clinical chart notes, and specific sizing details (brief/diaper size or pull-up/underwear size).
- **Urology Supplies:** Requires a prescription and clinical chart notes. Please include specific manufacturer part numbers if known.
- **Ostomy Supplies:** Requires a prescription and clinical chart notes. Please include specific manufacturer part numbers if known.
- **Nutrition Supplies (Oral / Supplemental):** Requires a prescription detailing specific diagnosis codes, the requested brand (e.g., Ensure, Boost), daily intake quantities, clinical chart notes, and a Letter of Medical Necessity (LMN).

3. Insurance Verification

- **Insurance Cards:** Provide clear copies of **all insurance cards** (both the **front and back** surfaces).

4. Reference Guide: Monthly Incontinence Allowables (must have 30 days between orders)

- **Disposable Absorbents:** Up to 200 total combined units per month (includes pullups/underwear, and briefs/diapers).
- **Liners/Boosters:** Up to 120 units per month.
- **Disposable Underpads:** Up to 150 units per month.
- **Medical Gloves:** Up to 2 boxes per month. Available in sizes Small (S), Medium (M), Large (L), and Extra Large (XL).

If you have any questions while gathering these items, please reach out to our Customer Care team. Thank you for choosing Ease-e Medical!

Best regards,

Customer Care / Intake Team

Ease-e Medical

731 S 8th St
Cañon City, CO 81212
Tele: 800-800-5914
Fax: 866-779-0036

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CUSTOMER REFERENCE SHEET

DATE _____ AGENCY WITH WHOM YOU ARE AFFILIATED_____

INSURED CLIENT'S FULL NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE NUMBER _____ FAX NUMBER_____

DATE OF BIRTH _____ ____ SEX: ☐ Male ☐ Female MARITAL STATUS: ☐ Single ☐ Married Tax ID _____

MEDICAID # _____ ___ MEDICARE # _____

SSN# _____ CLIENT'S HEIGHT _____ __ WEIGHT _____ __

CONTACT NAME _____ TELEPHONE: _____
(GUARDIAN, POA, RESPONSIBLE PARTY, ETC.)

EMAIL ADDRESS: _____ FAX: _____

---

*OTHER INSURANCE _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE NUMBER _____

INSURED'S NAME / ID NUMBER _____

* Copy of insurance card required for all private insurances

ORDERING AND/ OR PRIMARY
CARE PHYSICIAN'S NAME
_____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE NUMBER _____

FAX NUMBER _____

PRIMARY CARE PHYSICIAN'S
MEDICAID PROVIDER NUMBER _____ NPI # _____

DATE LAST SEEN _____

DIAGNOSIS(-ES) & NOTES _____

_____

Deliver to Location: ☐ Above Address ☐ Home

ADDRESS _____

CITY/STATE/ZIP _____

731 South 8th Street
Canon City, CO 81212
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Fax: 866-779-0036

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Client Required Signature Document

Assignment of Benefits	Change of Provider	Privacy Practices	Release of Information

Client's Name: **DOB:**

(Printed)

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF MEDICAL SUPPLY BENEFITS ORDERED FROM EASE-E MEDICAL, INC. TO BE PAID DIRECTLY TO EASE-E MEDICAL, INC..

I AM REQUESTING THAT EASE-E MEDICAL, INC. BE MY MEDICAID/MEDICARE SUPPLY PROVIDER EFFECTIVE AS OF _____ (DATE).

I HAVE RECEIVED: NOTICE OF PRIVACY PRACTICES (HIPAA) & PATIENT RIGHTS & RESPONSIBILITIES, CUSTOMER INFORMATION HANDOUT, MEDICARE DMEPOS SUPPLIER STANDARDS, SATISFACTION SURVEY, INPUT INTO MY PLAN OF SERVICE (IF APPLICABLE).

I HAVE RECEIVED EDUCATION/TRAINING THAT INSTRUCTIONS ON HOW TO PROPERLY USE/APPLY ALL PRODUCTS THAT I RECEIVE FROM EASE-E MEDICAL ARE INCLUDED WITH OR ON THE PACKAGING OF EACH ITEM.

I HAVE RECEIVED INSTRUCTION ON WHAT TO DO/WHO TO CALL IN CASE OF AN EMERGENCY AND DO NOT HAVE ANY QUESTIONS.

ASSIGNMENT OF BENEFITS AUTHORIZED FOR THE FOLLOWING SUPPLIES:

1. _____ 2. _____

3. _____ 4. _____

Client's or Authorized Representative's Signature **Date**
(If client's signature is not legible, please note that it is client's signature)

Relationship to Client (must be self or authorized representative)

If you would like medical information disclosed, please list the following individuals who may receive the information:

_____ _____ _____

THIS FORM MUST BE FILLED OUT COMPLETELY, SIGNED, DATED AND RETURNED TO THE APPROPRIATE ADDRESS LISTED ABOVE.

Illinois Medicaid Change of Provider Form

This form must accompany the new Prior Authorization Request (PAR) Form when a client has a current and active PAR with another provider.

Client Information

Client Name:	Medicaid ID#:
Date of Birth:	Current PAR Number (if known):

Previous Provider Information

Name:	Last Day of Services:

New Provider Information

Name: Ease-e Medical	Provider ID#: 470842353003
Client Start Date of Service:	Provider Signature:

This notice is to inform you that I, _____
(Client's name)

have changed providers effective: _____
(Date)

I am changing from provider: _____
(Provider's name)

to provider: Ease-e Medical
(New provider's name)

The following services/equipment will be affected by this change:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
Client's Signature or (Guardian if client cannot sign) (Date)

Client's address: _____
(Address line 1)

_____
(Address line 2)

_____
(City, State and Zip Code)

Revision date: January 21, 2025

731 S 8th St
Cañon City, CO 81212
Tele: 800-800-5914
Fax: 866-779-0036

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Customer Information Handout

Welcome! Thank you for choosing Ease-e Medical to be your medical equipment/supplies supplier. This handout provides you with basic information that relates to your healthcare. Please keep this handout for reference and call our office at any time you have questions.

Specifically, this handout shares information with you about the following:

Our commitment in providing quality services and products, our grievance procedure, patient communication form, your rights and responsibilities as a customer, Medicare supplier standards, guidelines for infection control in the home, our service, delivery and warranty policies, our billing and payment policies, Notice of Privacy Practices.

We are dedicated to providing the highest level of service, professionalism and most optimal medical supplies to our customers. We accept only those customers whose needs, as identified by the referring source, can be met by the services we offer. We not only provide quality medical products, we genuinely care for the customers we serve.

Our services include the following: Customer instruction and training on all products provided, experienced delivery and office staff to assist you, routine delivery and set-up, assistance with reimbursement billing questions, in relation to insurance carrier requirements.

At the end of this handout you will be asked to acknowledge that you received this handout and that you have read and understand the information we have provided to you.

SCOPE OF SERVICES

Disposable Supplies	Medical equipment/supplies	Specialty equipment/supplies	Bariatric equipment/supplies
♦ Incontinence Supplies ♦ Nutrition ♦ Ostomy ♦ Urology ♦ Gloves & Infection Control	♦ Walkers ♦ Quad Canes ♦ Commodes (retail) ♦ Bathroom Safety Aids	♦ Blood Pressure Monitors	♦ Manual Wheelchairs (retail) ♦ Commodes (retail) ♦ Walkers

Geographic Coverage: Our Colorado distribution center has been serving the Colorado area since 1992. We also bill Medicare and Medicaid in Nebraska, Iowa, and Illinois, and provide retail services in Indiana, Delaware, Connecticut and Kansas.

Mission Statement: As your partner in healthcare, Ease-e Medical Inc. provides quality products, personal service, and passionate advocacy for people who have intellectual and physical disabilities.

Compliance and Commitment: Ease-e Medical is committed to complying with all federal and state regulations. If you have any questions or concerns regarding any of our activities, please contact us at 719-276-1703 or 800-800-5914. Ease-e Medical is a fully accredited corporation. The certification is given by ACHC (Accreditation Commission for Health Care, Inc.). The ACHC number is 919-785-1214 and website www.achc.org.

Client Grievance Procedure: All of our customers are very important to us. So that we can resolve any problems that arise in a rapid and effective manner, we have developed the following client grievance procedure: 1. When you have a concern, you can speak to a staff member at the office location. 2. If you do not want to speak to a staff person or if the issue you have involves our employee, you can speak with the Director of Operations or Compliance Officer at the Colorado office.

Contact Information:
Colorado office: Ease-e Medical, Inc., 731 S. 8th St., Canon City, CO 81212; 800-800-5914; 719-276-1703; Fax: 866-779-0036.
In case of an EMERGENCY, please call 911, go to the nearest emergency room, contact your physician or other medical personnel. To reach us after hours, you may leave a message on the answering machine or through our website at: www.ease-estore.com.

We have included a ***Client Communication Form*** on the following page for you to complete should you wish to contact us.

Client Communication Form

Ease-e Medical strives to provide the highest quality healthcare services to all our clients. That is why your concerns are our concerns. To ensure that our services meet your complete satisfaction, we ask you to describe any complaint, problem, concern or compliment you may have.

After completing this form, please tear this page out of the handout and mail to the service location. The manager of your servicing location will research your concern in order to resolve all complaints and / or problems.

We appreciate your candid comments as well as your assistance in helping us to continually improve our service(s) to our valued customers.

Name: _____

Date of Service: _____

Telephone Number: (_____) _____ - _____

Please describe your compliment / concern:

_____

_____

_____

**********OFFICE USE ONLY**********

Action taken/Resolution:

_____

_____

_____

_____

Date Resolved: _____

Manager's signature: _____ Date: _____

Patient's Bill of Rights and Responsibilities

You have the right to:

1. Considerate and respectful service. 2. Obtain service without regard to race, creed, national origin, sex, age, disability or illness, or religious affiliation. 3. Confidentiality of all information pertaining to you, your medical care and service. 4. A timely response to your request for service and to expect continuity of services. 5. Select the medical equipment/supplies supplier of your choice. 6. Make informed decisions regarding your care planning. 7. Be told what service will be provided in your home, how often and by whom. 8. An explanation of charges including policy for payment. 9. Agree to or refuse any part of the plan of service or plan of care. 10. Voice grievances without fear of termination of service or other reprisals. 11. Have your wishes honored as they apply to advance directives you have formulated. 12. Have your communication needs met.

You have the responsibility to:

1. Ask questions about any part of the plan of service or plan of care that you do not understand. 2. Protect the equipment/supplies from fire, water, theft or other damage while it is in your possession. 3. Use the equipment/supplies for the purpose for which it was prescribed, following instructions provided for use, handling care, safety and cleaning. 4. Supply us with needed insurance information necessary to obtain payment for services and assume responsibility for charges not covered. 5. You are responsible for settlement in full of your account. 6. Be at home for scheduled service visits & deliveries or notify us in advance to make other arrangements. 7. Notify us immediately of: a. equipment/supplies failure, damage or need of supplies. b. Any change in your prescription or physician. c. Any change or loss in insurance coverage. d. Any change of address or telephone number, whether permanent or temporary. e. Discontinued equipment/supplies or services. f. Any home health episodes of care, skilled nursing facility and/or hospital stays. 8. Be respectful of the property owned by our company and considerate of our personnel. 9. Contact us if you acquire an infectious disease during the time we provide services.

Cleaning Procedures for Our Products: Ease-e Medical ensures that at the time of delivery, the equipment has been cleaned and disinfected. When this equipment/supplies is picked up it will be contained and transported to our warehouse for a thorough cleaning and disinfecting.
While this product is in your home, please follow the steps below to keep it clean. 1. Unplug all electrical equipment before cleaning. 2. All of our equipment can be cleaned using a damp soft cloth and mild detergent. 3. Never use ammonia or bleach solution while cleaning the equipment/supplies.
If you have any questions, please do not hesitate to contact our office at the number on the cover of this handout.

Important Electrical Safeguards

Improper Use of This Equipment Will Result In Electrical Shock and/or Damage to the Equipment: 1. Do not use an extension cord with this equipment/supplies. 2. Always ensure that this equipment/supplies is properly grounded. Per Article 250 of the National Electrical Code, where applicable, this equipment/supplies has been supplied with a three-pronged power cord, which should be inserted into a grounded receptacle, or used with a properly grounded adapter. 3. Some forms of transportable equipment may be used outdoors and are powered by an auxiliary power source (batteries). Non-transportable equipment/supplies should be used indoors only. 4. Do not use this equipment/supplies near water. 5. Do not place liquid on or near electrical equipment/supplies. 6. Always place equipment / supplies on a firm, stable base. 7. Report any problems with the equipment/supplies. If the equipment/supplies is not working properly or has been damaged please contact a Customer Service Representative at the phone number located on the front page of this handout.

FOR OUR CUSTOMERS WITH SPECIAL ELECTRICAL NEEDS: In order to request "priority service" from your utility in the event of a power outage follow these three easy steps to have your account flagged. 1. Obtain a letter from your doctor stating the need for priority service due to "life support" equipment/supplies. 2. Call your local utility for your local district's office address. 3. Mail the doctors letter to your district's office.

Emergency Preparedness Information: In the event of an emergency or natural disaster where delivery services may be delayed for long periods, it may be necessary to obtain some disposable supplies from local retailers. It is recommended that at least a 3-day supply be kept on hand for emergency use. Please follow the manufacturer's instructions regarding the storage of liquid nutritional supplements.

Service, Delivery and Warranty:

Business Hours: Our hours of operation are 8:00 am-5:00 pm Monday-Thursday, and 8:00 am – 3:00 pm Fridays, closed weekends and holidays.

Delivery Deliveries are provided on purchases. It is preferable that routine and repeat orders be called in 24 to 48 hours in advance. *In many cases we can also provide you with a courtesy call when ordering regularly.*

Purchased equipment/supplies and Warranties: New equipment/supplies is subject to the manufacturer's warranty. Refer to the warranty information provided to you at the time of purchase. All warranties will be honored under applicable state laws.

Service and Repair: Service or repair on equipment/supplies purchased from our company that is no longer covered by the manufacturer's warranty will be subject to current labor charges. The customer will be informed of their responsibilities regarding the ongoing care and service of the equipment/supplies and will be provided with maintenance instructions and how to obtain any service required. All service and repair must be scheduled by calling the office during regular business hours.

Financial Policy: All new equipment/supplies setups/orders going on account require prior verification of insurance coverage before equipment/supplies are setup or delivered. If this is not possible due to a weekend or other after-hours setup, verification must be done on the next business day. 1. We do not guarantee coverage of or payment of insurance claims. 2. We do not guarantee any time frame for processing of insurance claims or subsequent billing from our office. It will be done in as timely a manner as possible.

Insurance Coverage: Customer's Responsibility: 1. Provide us with all insurance information necessary to file your claim. 2. Notify our office of any changes or loss of insurance coverage. 3. Pay all deductible and balance remaining after secondary insurance is filed. 4. The customer is responsible for payment in full of all claims not covered by insurance. You will be informed before delivery if we know that an item is not covered and assignment will not be accepted. 5. Any arrangements or agreement for payment other than those described above must have approval from the location manager or designee. Special terms and approval signature must be documented on original paperwork.

Medicare Claims: Durable medical equipment/supplies is covered under your Medicare Part B benefit. If Medicare is your insurance carrier and denies payment, you will be notified. At that time, if you wish to keep the equipment/supplies it may be converted to private rental or purchase. In most cases, if you have supplemental insurance, the deductible amount and the 20% are paid by other insurance. We will follow through with the appeal process on Medicare claims that are denied.

The customer is also advised that: 1. Inexpensive, routinely purchased durable medical equipment/supplies may be rented or purchased. 2. Some types of equipment/supplies will be subject to a one-month minimum rental. 3. Rental charges will be assessed until we are notified to pick up the equipment/supplies. 4. Any charges incidental to the use or operation of the equipment/supplies (such as electricity) is the responsibility of the customer. 5. There is no charge for delivery or pickup of rental equipment/supplies. 6. All claims, assigned or non-assigned, will be filed on behalf of the patient.

Billing and Payment Policy: Customers are responsible for payment in accordance with our company's terms. Assignment of benefits to a third party does not relieve the customer of the obligation to ensure full payment. Billing third party payers is not an obligation, but rather a service we offer if all necessary billing information and signatures are provided.

Medicare: We may accept Medicare Part B assignment, billing Medicare directly for 80% of allowed charges and billing the beneficiary the 20% payment and any deductible. Presentation of your Health Insurance Card is necessary.

Medicaid: We may provide equipment/supplies to Medicaid recipients upon verification and approval of coverage status and medical justification. Presentation of your State Beneficiaries Identification Card and personal ID are required.

Private Insurance: We may bill private insurance carriers upon verification and approval of coverage status and medical justification. You are responsible for providing our billing department with all necessary insurance information. You are also responsible for notifying us of any insurance changes. Presentation of your insurance card and personal ID are required. Remember, billing a third party insurance ***does not*** guarantee payment. Financial responsibility remains with you, the client.

Advance Medical Directives: Advance Medical Directives are legal documents that allow you to give directions for your future medical care. They can assist you in communicating your choices should you become physically or mentally unable to do so.

You have the following rights under state law: 1. Make decisions regarding medical care. 2. Accept or refuse medical or surgical treatments. 3. Formulate advance directives

Two types of advance directives are living wills and durable power of attorney. You can use advance directives to limit certain life prolonging measures when there is little or no choice of recovery. For example, you may wish to address: 1. CPR – Cardiopulmonary Resuscitation. 2. IV Therapies. 3. Feeding Tubes. 4. Ventilators. 5. Dialysis. 6. Pain Relief.

Your choices regarding your medical care should be discussed with your family, friends, physicians, clergy and attorney.

At Ease-e Medical, our employees are not certified to administer CPR. If a situation would arise, the employee is instructed to call 911, unless you, your physician or legal representative informs us otherwise.

Please take the time to inform our office of any existing advance directives. Information regarding your advance directives can be given to our Customer Service Department.

Should you have any questions regarding our policy, please contact our Customer Service Department at the number shown on the front page of this handout.

731 S 8th St
Cañon City, CO 81212
Tele: 800-800-5914
Fax: 866-779-0036

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N O T I C E O F P R I V A C Y P R A C T I C E THIS NOTICE DESCRIBES HOW MEDIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice will tell you how we may use and disclose protected health information about you. Protected health information means any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In the header above, that information is referred to as "medical information." This notice also will tell you about your rights and our duties with respect to health information about you. In addition, it will tell you how to complain to us if you believe we have violated your privacy rights.

How We May Use and Disclose Health Information About You: We use and disclose health information about you for a number of different purposes. Each of those purposes is described below. 1. **For Treatment.** We may use health information about you to provide, coordinate or manage the services and support you receive from us and other providers. We may disclose health information about you to doctors, nurses, psychologists, social workers, direct support staff and other agency staff, and other persons who are involved in supporting you or providing care. We may consult with other health care providers concerning you and, as part of the consultation, share your health information with them. For example, staff may discuss your information to develop and carry out the health care product we provide to you. Staff may need to disclose health information to entities outside of our organization (for example, another provider or a state/local agency) to obtain new services for you. 2. **For Payment.** We may use and disclose health information about you so we can be paid for the health care product we provide to you. This can include billing a third party payor, such as Medicaid, Medicare or other state agency, or your insurance company. For example, we may need to provide the State or Department of Human Services information about the services we provide to you so we will be reimbursed for those products. 3. **For Health Care Operations.** We may use and disclose health information about you for our own operations. These are necessary for us to operate Ease-e Medical, Inc. and to maintain quality for our consumers. For example, we may use health information about you to review the health care product we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff. We also may use the information to study ways to more efficiently manage our organization, for licensing activities and/or for our compliance program. 4. **How We Will Contact You.** Unless you tell us otherwise in writing, we may contact you by either telephone or by mail at either your home or your workplace. At either location, we may leave messages for you on the answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see "Right to Receive Confidential Communications" on page 4 of this Notice. 5. **Health Related Benefits and Services.** We may use and disclose health information about you to contact you about health-related benefits and products. 6. **Marketing Communications.** We may use and disclose health information about you to communicate with you about a health care product to encourage you to purchase the product. This may be: a. To describe a health-related product that is provided by us; b. For your treatment; c. For case management or care coordination for you; d. We may communicate to you about products in a face-to-face communication by us to you. 7. **Disclosures to Family and Others.** We may disclose to a parent/guardian, personal representative, family member, other relative, a close personal friend, or any other person identified by you, health information about you that is directly relevant to that person's involvement with the products and supports you receive or payment for those products and supports. We also may use or disclose health information about you to notify, or assist in notifying, those persons of your location, general condition, or death. If there is a family member, other relative, or close personal friend that you do not want us to disclose health information about you to, please notify the Privacy Office at the appropriate address listed at the beginning of this document, or tell our staff member who is providing service to you. 8. **Disaster Relief.** We may use or disclose health information about you to a public or private entity authorized by law to assist in disaster relief efforts. 9. **Required by Law.** We may use or disclose health information about you when we are required to do so by law. 10. **Public Health Activities.** We may disclose health information about you for public health activities and purposes. This includes reporting health information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease, or one that is authorized to receive reports of child abuse and neglect. It also includes reporting for purposes of activities related to the quality, safety or effectiveness of a United States Food and Drug Administration regulated product or activity. 11. **Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information about you to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe you are a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by you or your personal representative; or (c) authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims, or, if you are incapacitated and certain other conditions are met, a law enforcement officer or other public official determines that immediate enforcement activity depends on the disclosure. 12. **Health Oversight Activities.** We may disclose health information about you to a health oversight agency for activities by law, including audits, investigation, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations. 13. **Judicial and Administrative Proceedings.** We may disclose health information about you in the course of any judicial or administrative proceeding in response to an order of the court or administrative hearing. We also may disclose health information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed. 14. **Disclosures for Law Enforcement Purposes.** We may disclose health information about you to a law enforcement official for law enforcement purposes: a. As required by law. b. In response to a court, grand jury or administrative order, warrant or subpoena, c. To identify or locate a suspect, fugitive, material witness or missing person, d. About an actual or suspected victim of a crime and that person agrees to the disclosure. If we are unable to obtain that person's agreement, in limited circumstances, the information may still be disclosed, e. To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct, f. About crimes that occur at our facility, g. To report a crime in emergency circumstances. 15. **Coroners and Medical Examiners.** We may disclose health information about you to a coroner or medical examiner for purposes such as determining cause of death. 16. **Funeral Directors.** We may disclose health information about you to funeral directors as necessary for them to carry out their duties. 17. **Research.** Under certain circumstances, we may use or disclose health information about you for research. Before we disclose health information for research, the research will have been approved through an approval process that evaluates the needs of the research project with your needs for privacy of your health information. We may, however, disclose health information about you to a person who is preparing to conduct research to permit them to prepare for the project, but no health information will leave our office during that person's review of the information. 18. **To Avert Serious Threat to Health or Safety.** We may use or disclose protected health information about you if we believe the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We also may release information about you if we believe the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody. 19. **National Security and Intelligence.** We may disclose health information about you to authorized federal officials for the conduct of intelligence, counter-intelligence, and other national security activities authorized by law. 20. **Protective Services for the President.** We may disclose health information about you to authorized federal officials so they can provide protection to the President of the United States, certain other federal officials, or foreign heads of state. 21. **Inmates; Persons in Custody.** We may disclose health information about you to a correctional institution or law enforcement official having custody of you. The disclosure will be made if the disclosure is necessary: (a) to provide health care products to you; (b) for the health and safety of others. 22. **Workers Compensation.**

We may disclose health information about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault. 23. **Other Uses and Disclosures.** Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying the Privacy Officer in writing at the appropriate address listed at the beginning of this document of your desire to revoke it. However, if you revoke such an authorization, it will not have any effect on actions taken by us in reliance on it.

Your Rights With Respect to Health Information About You: You have the following rights with respect to health information that we maintain about you: 1. **Right to Request Restrictions.** You have the right to request that we restrict the uses or disclosures of health information about you to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to: (a) a family member, other relative, a close personal friend or any other person identified by you; or, (b) to public or private entities for disaster relief efforts. For example, you could ask that we not disclose health information about you to your brother or sister. 2. You may request a restriction at any time. Requests for a restriction should be sent in writing to the Privacy Office at the appropriate address listed at the beginning of this document, and tell: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and (c) to whom you want the limits to apply. 3. We are not required to agree to any requested restriction. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction. 4. **Right to Receive Confidential Communications.** You have the right to request that we communicate health information about you to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail. We will not require you to tell us why you are asking for the confidential communication. 5. To request confidential communication you must do so in writing to the Privacy Office at the appropriate address listed at the beginning of this document. Your request must state how or where you can be contacted. We will accommodate your request. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you. 6. **Right to Inspect and Copy.** With a few very limited exceptions, you have the right to inspect and obtain a copy of health information about you. Your request should state specifically what health information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing. We will act on your request within thirty (30) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying. We may deny your request to inspect and copy health information if the health information is: Information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding. If we deny your request, we will inform you of the basis for the denial, how you may have our denial reviewed, and how you may complain. If you request a review of our denial, it will be conducted by a licensed health care professional designated by us who was not directly involved in the denial. We will comply with the outcome of that review. 7. **Right to Amend.** You have the right to ask us to amend health information about you. You have this right for so long as we maintain the health information. To request an amendment, you must submit your request in writing to the Privacy Office at the appropriate address listed at the beginning of this document. Your request must state the amendment desired and provide a reason in support of that amendment. We will act on your request within sixty (60) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying. If we grant the request, in whole or in part, we will seek your identification of, and agreement to, share the amendment with other relevant persons. We will also make the appropriate amendment to the health information by appending or otherwise providing a link to the amendment. We may deny your request to amend health information about you. We may deny your request if it is not in writing and does not provide a reason in support of the amendment. In addition, we may deny your request to amend health information if we determine that the information: a. Was not created by us, the person or entity that created the information is no longer available to act on the requested amendment; b. Is not part of the health information maintained by us; c. Would not be available for you to inspect or copy; or, d. Is accurate and complete. If we deny your request, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreement with our denial. We may prepare a rebuttal to that statement. Your request for amendment, our denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the health information involved or otherwise linked to it. All of that will then be included with any subsequent disclosure of the information, or, at our election, we may include a summary of any of that information. If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the health information involved. You also will have the right to complain about our denial of your request. 1. **Right to an Accounting of Disclosures.** You have the right to receive an accounting of disclosures of health information about you. The accounting may be for up to six (6) years prior to the date on which you request the accounting but not before May 1, 2008. Certain types of disclosures are not included in such an accounting: a. Disclosures to carry out payment and the Organization operations; b. Disclosures of your health information made to you; c. Disclosures that are incident to another use or disclosure; d. Disclosures that you have authorized; e. Disclosures for disaster relief purposes; f. Disclosures for national security or intelligence purposes; g. Disclosures to correctional institutions or law enforcement officials; h. Disclosures that are part of a limited data set for purposes of research and/or public health; i. Disclosures made prior to May 1, 2008. Under certain circumstances your right to an accounting of disclosures to a law enforcement official or a health oversight agency may be suspended. Should you request an accounting during the period of time your right is suspended, the accounting would not include the disclosures to a law enforcement official or to a health oversight agency. To request an accounting of disclosures, you must submit your request in writing to the Privacy Office at the appropriate address listed at the beginning of this document. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we receive your request and may not include dates before May 1, 2008. Usually, we will act on your request within sixty (60) calendar days after we receive your request. Within that time, we will either provide the accounting of disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary. There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee. 1. **Right to Copy of this Notice.** You have the right to obtain a paper copy of our Notice of Privacy Practices. You may obtain a paper copy even though you agreed to receive the notice electronically. You may request a copy of our Notice of Privacy Practices at any time. 2. To obtain a paper copy of this notice, contact the Privacy Officer at the appropriate address listed at the beginning of this document.

Our Duties: 1. **Generally.** We are required by law to maintain the privacy of health information about you and to provide individuals with notice of our legal duties and privacy practices with respect to health information. We are required to abide by the terms of our Notice of Privacy Practices in effect at the time. 2. **Our Right to Change Notice of Privacy Practices:** We reserve the right to change this Notice of Privacy Practices. We reserve the right to make the new notice's provisions effective for all health information that we maintain, including that created or received by us prior to the effective date of the new notice. 3. **Availability of Notice of Privacy Practices.** You may obtain a copy of our Notice of Privacy Practices by mail. 4. **Effective Date of Notice.** The effective date of the notice will be stated on the first page of the notice. 5. **Complaints.** You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. To file a complaint with us, contact the Privacy Officer at the appropriate address listed at the beginning of this document. All complaints should be submitted in writing. To file a complaint with the United states Secretary of Health and Human Services, send your complaint in care of: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW., Washington, D.C. 20201. You will not be retaliated against for filing a complaint. 6. **Questions and Information.** If you have any questions or want more information concerning this Notice of Privacy Practices, please contact the Privacy Officer, Mark Norris at the Colorado location at 800-800-5914.