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Bozeman, MT 59718
Phone: (406) 586-2626 Fax: (406)586-2676
Web: www.springintegrativehealth.com

New Naturopathic Patient Forms Please return your completed forms *at least two business days* prior to your appointment. Thank you!

Welcome to Spring Integrative Health! We are so glad you found us. In order to provide the best possible care, it is important to us that you understand our policies and practices. Therefore, we request that you please read, make sure you understand, and sign the documents included in this new patient packet prior to beginning our work together.

New Patient Forms

- Patient Communications Policy
- Financial and Cancellation Policies
- Credit Card Authorization
- Consent for Treatment
- Informed Consent for Telemedicine and AI charting
- Notice of Privacy Practices & Acknowledgment of Receipt of Notice of Privacy Practices
- Interoffice Collaborative Care Release
- Authorization to Leave Messages
- Clinical Profile
- Spring Intake Form

Additionally, if you would like your other health care provider(s) to send us your past labs or other medical records, please complete the Authorization to Release Confidential Health Information/Medical Records and provide it to them.

Thank you for taking the time to fill out these forms. This ensures we can provide quality care.

If you have any questions, please call the office at 406-586-2626.

We look forward to working with you as part of your healthcare team!

Warmly,
The Spring Integrative Health Team
Dr Eryn J. O'Connell, PLLC

PATIENT COMMUNICATIONS POLICY

In order to ensure the safety and confidentiality of your health information, we may use the HIPAA-compliant Optimantra Electronic Medical Records System, Deepcura AI charting assistance, and a secure Patient Portal.

Once your visit is booked, we will send you a confirmation e-mail and an invitation to the Patient Portal.

· **As a patient of Spring Integrative Health and/or Dr Eryn J. O'Connell, PLLC, please send all health-related messages to your provider via the HIPAA-compliant Patient Portal.** This ensures all messages are secure and retained in your medical record. In addition to sending secure messages, through your account on the Patient Portal, you can also view your lab results and access your medical records. You can find a link to the Patient Portal on the "Established Patients" page of our website, where you can log in with your unique username and password.

· **Please do not e-mail health-related information and questions outside of the secure Patient Portal, as e-mail can never be guaranteed to be confidential or secure.** If you do e-mail health information, it will become part of your medical record, and you will be directed to the Patient Portal.

· Patient Portal messages may be used for clarification of your most recent treatment plan, or to send an update on your health information, but they are not a substitute for an appointment with your provider. If you have any additional concerns or questions, please schedule an appointment. In cases where a Patient Portal message response is not appropriate or sufficient, you will be asked to schedule an appointment to ensure that your concerns are properly addressed.

· Your providers will do their best to respond to Patient Portal messages within three business days (72 hours). If you do not receive a response, please follow up with another message or by telephone at 406-586-2626. Your call will be returned as soon as possible.

· We do not provide emergency or urgent care services. If an emergency situation arises, call 911. For mental health resources nearby, call 211, the National Suicide Prevention Hotline: 800-273-8255, or Bozeman's 24-hour crisis line "The Help Center": (406) 586-3333.

Patient Portal Message Billing Policy:

· Patient Portal messages require the same time and expertise as scheduled consultations. Due to an increasing volume of messages of this nature, we have a Patient Portal Message Billing Policy. **For anything other than quick clarifications regarding your most recent treatment plan and anything that takes more than 10 minutes of your provider's time, you will be billed for the time spent responding to your message. Your credit card on file will be charged for this fee.**

· You will **NOT** be billed for: Clarification of your most recent treatment plan, refill requests, or billing and scheduling questions. If you wish to send an update on your care and don't need a reply, please put "No Reply Necessary" in the subject line to ensure you will not be billed.

Privacy Policy for Spring Integrated Health Using Zoom TEXT Services

Effective Date: December 17th, 2024

At Spring Integrated Health and/or Dr Eryn J. O'Connell, PLLC, ("we", "our", or "us"), we are committed to protecting the privacy and confidentiality of your personal health information. This Privacy Policy outlines how we collect, use, and protect your personal information, particularly in relation to our use of Zoom TEXT services for patient communication. Zoom is our phone and text service carrier.

By engaging with our services, you consent to the practices described in this Privacy Policy. If you do not agree with any part of this policy, please refrain from using our SMS communication services or respond with STOP to be taken off our SMS services.

1. Information We Collect

We may collect the following types of information when you engage with our services:

- **Personal Information:** Your name, phone number, email address, and any other contact information you provide to us for the purpose of receiving communications.

- **Health Information:** In accordance with Montana healthcare privacy laws, we may collect and process health-related information as part of your treatment and care, which could be communicated via SMS (e.g., appointment reminders, health tips, follow-up care instructions, supplement order/pickups, and any other general questions pertaining to your overall care while you are a client of ours).
- **SMS Communication Data:** This includes information related to the delivery, status, and content of SMS messages, such as message response rates, time of receipt, and interactions with the message (e.g., replying to confirm an appointment). This information will be used for record keeping purposes in regards to what has been communicated with you or with our facility in return.

2. How We Use Your Information

We use the information we collect for several purposes, including but not limited to:

- **Appointment Reminders and Confirmations:** Sending automated SMS reminders to confirm, cancel, or reschedule appointments.
- **Health and Wellness Communication:** Sending personalized health tips, updates, or other information related to your care and wellness.
- **Treatment Follow-up:** Providing you with follow-up instructions or reminders after visits or procedures.
- **Customer Support:** Responding to your inquiries, questions, supplement orders, or concerns submitted via SMS.
- **Compliance and Recordkeeping:** Maintaining records as required by Montana healthcare laws and regulations.

3. How We Share Your Information

We do not sell or rent your personal information. However, we may share your information in the following ways:

- **Service Providers:** We may share your information with trusted third-party service providers, including Zoom SMS (our SMS platform), who assist us with sending and managing SMS communications. These providers are required to keep your information confidential and use it solely for providing services to us.
- **Legal Requirements:** We may disclose your information if required by law, or in response to legal processes such as subpoenas, court orders, or government investigations.

4. Data Security

We take reasonable measures to protect your personal information from unauthorized access, use, or disclosure.

However, no method of transmission over the internet or electronic storage is 100% secure. While we strive to protect your information, we cannot guarantee absolute security. If at any time there is a breach of your personal healthcare information, swift notification to yourself and a written statement will be issued. As well as any investigations necessary into the breach of healthcare information.

5. Your Rights Regarding Your Information

As a patient, you have certain rights with respect to your personal and health information, including:

- **Access:** You may request access to the personal information we hold about you at any given time.
- **Correction:** You may request to update or correct any inaccuracies in your personal or health information at any given time.
- **Deletion:** You may request to have your information deleted, subject to legal or contractual obligations we may have.
- **Opt-out:** You may opt out of receiving SMS communications from us at any time by following the "STOP" instructions in our SMS messages or by contacting us directly.

To exercise these rights, please contact us at the contact information provided below.

6. Opting Out of SMS Communications

If you no longer wish to receive SMS communications from us, you can opt out at any time by replying "STOP" to any message you receive. You may also contact us directly through our secure email address, or by phone (both of these contacts have been listed below) to request removal from our SMS list.

7. Cookies and Tracking Technologies

Although we use SMS for communication, our website and other online services may use cookies or similar technologies for purposes such as improving user experience, tracking interactions, or offering personalized content. These technologies are not typically used in our SMS services, but are relevant to other digital interactions with our practice.

Please sign below acknowledging that you have read, understand, and agree to this Patient Communications Policy.

FINANCIAL AND CANCELLATION POLICIES

We require a credit card on file to hold your scheduled appointments, for charges to your account, and for any amounts past due. Please complete the credit card authorization provided.

Your credit card information is stored in a secure, encrypted manner and will be charged for any supplements shipped to you, outstanding balances on your account, and any late cancellation fees as set forth herein.

Payment: Payment is due in full at the time of service. For your convenience we accept cash, checks, and credit card. Please let us know if you plan to pay with cash or check instead of your card on file. Checks can be made payable to: Spring Integrative Health, PLLC **and/or** Dr Eryn J. O'Connell, PLLC,.

Returned Checks and Delinquent Accounts: An additional \$25.00 fee will be charged for any check returned for insufficient funds or otherwise dishonored. In the event that a patient's check is returned on more than one occasion, all future payments must be made via credit card or cash. Patient's accounts that are more than 60 days late will be sent to collections and the patient is responsible for all fees incurred by the collection agency or attorney. Patients with delinquent accounts will not be given the option to schedule and must pay balance before seeing providers.

No Insurance or Medicare: Spring Integrative Health, PLLC is a fee-for-service business and does not accept or bill insurance or Medicare for any services provided. Upon request, we will provide you with a statement showing your payment and a coded superbill that you may submit to your insurance company for possible reimbursement at an out-of-network rate depending on your individual plan. But we cannot guarantee that your insurance company will reimburse you for your appointments or fees. Payment reimbursement is subject to your insurance plan. You are ultimately responsible for the cost of your care to your insurance plan. You are ultimately responsible for the cost of your care.

Insurance billing for Dr Eryn J. O'Connell, PLLC, practicing at Spring Integrative Health: Insurance co-pays are due in full at time of service. Your insurance company may or may not cover the cost of the visit. *It is the patient's responsibility to be aware their coverage and benefits. Please contact your insurance company to find out what services are covered under your specific plan. If insurance denies a claim or the claim is deemed patient responsibility and will be applied to the patient's deductible, the patient or legal guardian consents to Dr. Eryn J. O'Connell, PLLC collecting payment for the visit via the credit card on file within 90 days of claim submission.* For established patients and lab follow up, if you choose to have a phone consult with Dr. Eryn, you will be charged the full visit fee that varies pending on length. Please be aware insurance companies may not cover these charges. Phone visits cannot address new concerns or follow-ups requiring physical exam.

Lab Tests: Insurance may cover some labs, depending on your individual plan, but if you choose to use your insurance rather than pay the lab company directly, **we cannot guarantee what your insurance may cover or what your out-of-pocket costs may be.** It is the patient's responsibility to understand his or her insurance coverage. To prevent the stress of unexpected bills, if you wish to use your insurance for lab testing, we recommend you contact your insurance company to understand your lab benefits prior to completing any lab tests.

Cancellation, Rescheduling and Missed Appointment Policy:

If you are unable to make your appointment, we respectfully request 24 hours (one business day) advanced notice so that we can open up that time space for someone else. **For any cancellation or appointment changes with less than 24 hours' notice and any missed appointments (no-shows), your credit card on file will be charged a no-show/late cancellation fee.**

For RETURN-PATIENT-VISITS, a \$50.00 no-show/late cancellation fee will be billed to your credit card on file, and for NEW-PATIENT-VISITS the full amount of the scheduled visit will be charged to your card on file. This no-show/late cancellation fee is non-refundable, but the amount may be used as a credit towards your next office visit if you reschedule within 30 days after your missed/cancelled appointment.

Financial Responsibility Statement: By signing below, I acknowledge that I have read, understand, and agree to the terms of Spring Integrative Health, PLLC's **and/or** Dr Eryn J. O'Connell, PLLC Financial and Cancellation Policies, and I

accept full financial responsibility for services rendered at time of service. I give Spring Integrative Health, PLLC **and/or** Dr Eryn J. O'Connell, PLLC permission to charge my credit card if I miss, cancel or reschedule an appointment with less than 24-hours' notice and for all balances overdue on my account.

Credit Card Authorization

Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC require a credit card on file. We will use this card for cancellations with less than 24 hours (one business day) notice and missed appointments, as well as any other charges as set forth in the Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell PLLC Financial and Cancellation Policies. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due for services provided or no-show or late cancellation fee due.

Please complete CARD INFORMATION below. Thank you in advance. Please sign below to acknowledge and agree to the following:

- I authorize Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC to charge my credit card as set forth in the Financial and Cancellation Policies. This includes authorization to charge my credit card on file as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with cancellation policy.
- I further authorize Spring Integrative Health PLLC to process the credit card on file as "Signature on File" for any future supplements, herbs, or medical supplies that would be shipped to me.
- I understand that my information will be saved for Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC security and future transactions on my account

Providers: -

Alisun Bonville, ND License AHC-NAT-LIC-801 MT
 Jennifer Krieger, ND License AHC-NAT-LIC-991 MT
 Eryn O'Connell, ND License AHC-NAT-LIC-2131 MT / ND.0000180 CO
 Breanna Slattery, ND License AHC-NAT-LIC-131130
 Rachel Day, ND **AHC-NAT-LIC-2134** 2134 LE VISAGE WELLNESS CENTER AND SPA
 Grace Weidlich, Health Coach

CONSENT TO TREATMENT

This Consent to Treatment provides important information regarding the services being provided by Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC. It is designed to inform you about our services and to obtain your informed consent for care. Please ask any questions you have regarding this document and before signing.

By signing below, I acknowledge and agree to the following:

I authorize Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC and the above listed providers to treat me in accordance with their scope of practice. I understand methods of treatment used by the various practitioners at Spring Integrative Health, in accordance with their training and scope of practice, may include, but are not limited to: botanicals, minor surgery, pharmaceutical prescription, homeopathy, physical medicine, biotherapeutic drainage, hydrotherapy, nutritional evaluation, acupuncture, massage, naturopathic oncology, physical manipulations, dietary and nutritional counseling, Naturopathic dietary testing, vitamin injections and IV therapy, Craniosacral Fascial Therapy (CFT), as well as others, which my healthcare providers deem appropriate.

Description of Naturopathic Medicine Services: Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Description of craino-sacral (CFT): I understand that CFT is intended to enhance relaxation, increase communication within the areas of the body-mind complex, to educate me and release possible physical, mental, energetic or emotional blocks that may create pain and disease. This allows my systems to take care of themselves. CFT is non-invasive, safe, and objective. CFT releases the fascial tension within the body, to allow more cerebral spinal fluid to flow, assisting the body to heal itself.

Description of Acupuncture: I understand that acupuncture will be performed by the insertion of sterile, disposable needles through the skin, and moxibustion is the application of heat at certain points on my body. I understand that any Chinese herbal formulas are prescribed specifically for me and are not to be shared with friends or family. I understand that the intention of treatment is to restore balance and improve functioning of my body, to relieve stress and pain on physical and/or emotional levels of my being. I further understand that part of treatment may include examination of my habits and lifestyle choices which may impact my health and the course and success of treatment. I have been informed that although rare, side effects may result from acupuncture treatment. These could include some minor pain or discomfort, localized bruising, small blisters, fainting, nausea, headache, gastrointestinal or allergic reactions. While temporary aggravation of pre-existing conditions may occur, this is usually a sign of deep inner healing or "Law of Cure".

Massage Therapy: I understand that massage therapy is intended to help rid the body of life's everyday stresses, reduce muscle pain, help alleviate the discomforts from the aches of certain ailments or just restore a neutral balance between the body and mind leaving me feeling rejuvenated and helping me to maintain a balance of wellbeing.

Health Coaching/Nutritional Counseling:

I understand that health coaching/dietary counseling is intended to help encourage a better lifestyle, not to diagnose a problem. In these sessions, I understand that I will be coached on healthy diet choices. I understand that all changes I make are my own to benefit a positive change in my life. I understand that all recommendations and treatments will be discussed with me before implementation and treatment begins, and that I am encouraged to ask questions, including potential risks, benefits, and alternatives. I understand that the U.S. Food and Drug Administration has not approved nutritional, herbal, and/or homeopathic substances for the treatment of specific diseases. I am at liberty to seek alternate opinions or care and may discontinue treatment at any time.

No Guarantee and Patient Responsibility: I understand that results from treatment are not guaranteed and that Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC does not make any representations, promises, claims, warranties, assurances or guarantees that my medical problems or conditions will be helped or cured by undergoing any treatments. I understand that as with all existing methods of diagnosis and treatment, there are both benefits and risks.

Potential Benefits: Restoration of health, mental well-being and the body's maximal functional capacity; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.

Potential Risks: Herbs, dietary supplements, and homeopathic remedies are available over the counter and generally considered safe based upon their long history of use. However, they could cause allergic reactions or unpleasant side effects which could possibly range from mild to severe. The interactions between herbs, and between herbs and medications are also not always thoroughly understood. While unlikely, it is possible to have an adverse reaction or experience a reduction or increase in the effect of other medications when taking herbs. These can have serious consequences for some medications, such as for the control of high blood pressure or blood sugar. Homeopathic medicines can potentially cause aggravation or worsening of current or pre-existing symptoms. There is also the risk of injuries, infection, pain, discomfort, discoloration, minor bruising, and blistering from venipuncture, other procedures or topical applications; burns from hot water/temperatures during hydrotherapy treatments; or soft tissue or bone injury from physical medicine and bodywork even though all such procedures are within normal range of joint motion. There may also be other potential risks which may be discussed and clarified in separate consents specifically applicable to such treatments. I am aware that unforeseeable complications could occur, and that while my Spring Integrative Health providers will make every reasonable effort to screen for contraindications to care, I do not expect them to be able to anticipate and explain all possible risks and complications.

Following Provider Instructions: I understand that the recommendations and treatments I receive including herbs, homeopathic medicines, nutritional supplements, and prescription medications are considered safe when used as instructed. **I understand that it is extremely important that I follow my provider's instructions.** I understand that following all instructions, whether orally and/or in writing, helps to improve the safety and outcomes of treatment.

Complete Medical History: I understand that some treatments may be inappropriate and unsafe if I have certain health conditions or take certain medications or supplements, whether prescribed or over-the-counter. For this and other reasons, I understand that it is vital that I truthfully and accurately disclose all health information requested by my provider as well as keep Spring Integrative Health updated as to any changes, including any new treatments or procedures I am undergoing. I understand that failure to do so may negatively affect my treatment outcome and the safety of any treatments I receive, and I understand that there shall be no liability on the part of Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC or my provider should I fail to do so.

Notice to All Female Clients Capable of Conceiving and Breastfeeding: I understand that some treatments could present a risk during pregnancy and breastfeeding, and I agree that I will notify my provider immediately if I am pregnant, become pregnant, am planning to become pregnant in the next three months, or if I am breastfeeding.

Notice Regarding Adjunctive Cancer Care/Integrative Oncology Care: For patients diagnosed with cancer, Spring Integrative Health, PLLC providers may offer adjunctive, integrative, and collaborative care alongside your other providers (medical, surgical, and radiation oncologists, as well as genetic counselors and therapists), but they do not treat malignancies. Spring Integrative Health's supportive naturopathic services are designed to mitigate the side effects of any conventional treatment you may undergo, as well as help you maintain health and quality of life during your treatment and recovery process. Therefore, if you have a diagnosis of cancer, we recommend that you be under the ongoing care of a physician with experience working with malignant conditions as well.

Independent Practitioners: I understand that my provider and each provider at Spring Integrative Health, PLLC has liability coverage through their own insurance coverage, separate from Spring Integrative Health, PLLC and that they choose to participate in this setting for the purposes of conducting their medical practice/business within an integrative group setting that allows collaborative care for the benefit of the patient. **Please see the Interoffice Collaborative Care release for more details.**

By voluntarily signing below, I certify that: I have read the foregoing Informed Consent for Treatment, or someone has read it to me. I understand the potential risks, benefits, and alternatives, and I have had the opportunity to ask questions, and my questions have been answered. I hereby voluntarily consent and agree to receive treatment at Spring Integrative Health, PLLC. I understand that I am free to withdraw my consent and to discontinue participation in treatment at any time, but that discontinuing consent does not remove past consent for therapy or treatments already consented to.

INFORMED CONSENT FOR TELEMEDICINE CONSULTATIONS and AI charting Assistance

The purpose of this form is to obtain your informed consent for telemedicine consultations with your healthcare provider at Spring Integrative Health, PLLC. Telemedicine involves the use of electronic communications to enable the healthcare provider at a different location from the patient to share medical information with that patient for the purpose of improving access to patient care. The information may be used for diagnosis, treatment, follow-up and/or education. During a telemedicine consultation, your provider will be providing care to you via live two-way audiovisual electronic communications instead of in person. Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC uses Zoom and/or Optimantra as the technology service to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in.

Expected benefits of a telemedicine consultation are:

- Improved access to medical care from a location of the patient's choosing.
- More efficient medical evaluation and management.
- Reduction of spread of communicable disease by not coming to a healthcare office.

Potential risks associated with the use of telemedicine include, but not limited to:

- There is the potential that conditions that could be diagnosed with an in-person visit may go undetected in a remote encounter, especially because a full physical exam cannot be performed.
- The video connection may not work, or it may stop working during the consultation, or there may be other technical difficulties or failures during the consultation.
- The video picture or information transmitted may not be clear enough to be useful for the consultation or to allow for appropriate care. For instance, certain parameters of the physical examination cannot be assessed or tested remotely. In addition, there may be poor resolution of images. This may cause a delay in medical evaluation and treatment.

· Security protocols may fail, causing a breach of privacy of personal medical information and/or unauthorized access to the video connection during the consultation. Telehealth is NOT an Emergency Service, and in the event of an emergency, call 911.

By signing this Informed Consent to Telemedicine, you acknowledge and attest that you understand and agree to the following with respect to telemedicine services:

1. I understand it is up to my Spring Integrative Health and Dr. Eryn J. O'Connell, PLLC provider to determine whether or not my specific clinical needs are appropriate for a telemedicine consultation. I understand that I may be required to discontinue the telemedicine consult and to see a provider in-person if my Spring Integrative Health provider determines that I need to receive a more thorough physical examination or that the videoconferencing connections are not adequate for the situation or to provide appropriate care for any reason.
2. I understand that the federal and state laws that protect the privacy and confidentiality of health information also apply to telemedicine, and all medical reports resulting from the telemedicine consultation are part of my medical record. I understand that there will be no recording of any of the online sessions and that all information disclosed within telemedicine sessions and in the written records pertaining to those sessions are treated with the same confidentiality as information from in-person visits pursuant to the Spring Integrative Health HIPAA Notice of Privacy Practices.
3. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone. I agree to take full responsibility for the security of any communication on my own computer and devices and in my own physical location. I also understand that I am responsible for using this technology in a private location so that others cannot hear my conversation.
4. I understand there is a risk of technical failures during the telemedicine encounter, including difficulties with internet connectivity, hardware, software, equipment, and/or services supplied by a third party, and that these technical failures are beyond the control of Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC. I understand Spring Integrative Health, PLLC cannot make any guarantee that such services will work as expected, and I agree to hold harmless Spring Integrative Health, PLLC for delays in evaluation or for information lost due to such technical failures.
5. I understand that alternatives to telemedicine consultation, such as in-person services, are available to me, and in choosing to participate in a telemedicine consultation, some medical services may not be available.

By signing this Informed Consent for Telemedicine, I confirm and agree that: I have read this informed consent form, or someone has read it to me. I understand the contents of this form including the risks and benefits of the telemedicine consultation and my questions have been answered. I hereby give my informed consent to participate in telemedicine consultations with the Spring Integrative Health, PLLC providers, and I intend this informed consent to cover the entire course of my care with Spring Integrative Health, PLLC.

AI charting assistance: I understand that my healthcare provider may use artificial intelligence (AI)–assisted software to support medical charting and documentation through DeepCura, which is integrated into the charting system used by the clinic, Optimanta. This technology helps streamline record-keeping and improve the accuracy and efficiency of medical charting. I acknowledge that all information entered into the system will be kept confidential in accordance with HIPAA and applicable privacy laws. My provider will review and confirm the accuracy of all AI-generated notes before they become part of my permanent medical record. I understand that I may ask questions about this process at any time and may withdraw my consent to the use of AI in my charting. By signing below, I consent to the use of AI-assisted software in my medical documentation.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS REQUIRED BY LAW AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC ("we," "our," or "us") respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing our care and services to you. "Protected health information" is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care. For example, your protected health information includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and

payment information relating to these services. Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of Your Protected Health Information Federal and state laws allow us to use and disclose your protected health information for purposes of treatment, payment, and health care operations without your additional authorization.

For treatment:

- Information obtained by a physician, nurse, acupuncturist, massage therapist or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan when we are contracted providers. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you for amounts due which have not been paid at the time of service. We may send your account to a collection agency and take other measures permitted by law to collect money you owe us that we have been unable to collect from you by our normal billing processes.

For health care operations:

- We use your medical records to assess the quality of and improve our services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We also may use and disclose protected health information to tell you about treatment alternatives or health-related services that may be of interest to you. We will not, however, send you communications about health-related or non-health-related products or services that are subsidized by a third party without your authorization.

You're Health Information Rights: The health and billing records we create and store are the property of Spring Integrative Health, PLLC and Dr. Eryn J. O'Connell, PLLC; the protected health information in it, however, generally belongs to you.

- You may request and receive from us a paper copy of our most current Notice of Privacy Practices (this Notice) and ask questions about this Notice.
- You may ask us to restrict certain uses and disclosures of your protected health information. You must deliver this request in writing to us. We are not required to agree to those restrictions, but we will review your request and inform you of any action taken. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.
- In most cases you may inspect and obtain a copy of your protected health information. You must make this request to the Office Manager in writing. We have a form available for this type of request. We may charge you a minimum fee of \$10.00 or the costs of copying, mailing, and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances. In case of a denial to allow you access to your records, you may have another health care provider of the same specialty review your records except in certain circumstances.
- If you feel that the protected health information that we maintain about you is incorrect or incomplete, you may ask us to change our record of your health information. You must give us this request in writing, and you must include a reason that supports your request. In certain cases, we may deny your request for amendment, if for example, you ask us to amend information that we did not create, or you ask us to amend a record that is already accurate and complete. If your request is denied, you may write a statement of disagreement. It will be stored in your medical record and included with any release of your records.
- You may request and receive an accounting of disclosures of your protected health information that we have made since April 14, 2003, for most purposes other than treatment, payment, or health care operations. This accounting will not include disclosures to third party payers. You must make your request in writing to our Office Manager and may receive this information without charge once every 12 months. We will notify you of the cost

involved if you request this information more than once in 12 months. Your request must specify the time period. The time period may not be longer than 1 year and may not include dates before April 14, 2003.

- You may ask that your health information be given to you by another means or at another location. For instance, you may request that we contact you at a different residence or PO Box. To request confidential communication of your PHI, you must submit a signed and dated written request to our Office Manager, telling us how or where you would like to be contacted. We will accommodate all reasonable requests.
- You may cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have received your revocation. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance

Notification of Family and Others:

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it. We may ask you to provide a written statement listing persons with whom you wish your health information to be shared, and those to whom you do not wish your information to be given.

Incidental Disclosures:

- Spring Integrative Health will make reasonable efforts to avoid incidental disclosures of protected health information.
- Examples of ways in which we work to protect against such disclosures are: having patients check out one at a time at the front desk, keeping patient charts in areas where only appropriate staff have access to them, protecting the anonymity of our patients and the confidentiality of their PHI in conversations in areas where other patients or unauthorized personnel are present or might overhear, asking and gaining your permission before admitting students to observe or assist in your care.

Minors: If you are a minor who has lawfully provided consent for treatment and you wish for us to treat you as an adult for purposes of access to and disclosure of records related to this treatment, you may notify the doctor or our Office Manager.

Other Disclosures and Uses of Protected Health Information: We are permitted to use and disclose your protected health information without your authorization as follows:

- **As required by law.** We must disclose protected health information about you when required to do so by law.
- **To medical researchers:** if the research has been approved and has policies to de-identify your health information.
- **To Funeral Directors/Coroners,** consistent with applicable law, to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA),** relating to problems with food, supplements, and products.
- **To comply with workers' compensation laws,** you make a workers' compensation claim.
- **For Public Health and Safety purposes as allowed or required by law:** To prevent or reduce a serious, immediate threat to the health or safety of a person or the public To public health or legal authorities in order to of a person or the public. To public health or legal authorities in order to protect public health and safety. To prevent or control disease, injury, or disability. To report vital statistics such as births or deaths.
- **To report suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety oversight activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.
- **Business Associates.** We may disclose protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Other Uses and Disclosures of Protected Health Information: Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Our Responsibilities: We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.

Health Information Security: Spring Integrative Health, PLLC maintains physical, administrative, and technical security measures to safeguard your protected health information and requires any staff to follow such security policies and procedures, as well as limits access to health information about patients to those individuals who need it to perform their job responsibilities.

Changes to This Notice: We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you, as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, the new Notice will contain the new effective date. You may always obtain a copy of our current Notice by contacting us as indicated below or asking for a copy at the time of your next consultation.

Help or Complaints: If you have questions about this notice, want more information, want to request forms for submitting written requests, or want to report a problem about the handling of your protected health information, you may contact *Spring Integrative Health, PLLC*. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer listed below can provide you with the appropriate address upon request. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint. If you have any questions or complaints, please contact:

Privacy Officer: Dr. Alisun Bonville, ND
 Phone (406) 586-2626
 Email drbonville@springintegrativehealth.com

Effective September 1, 2021

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

By signing below, I acknowledge that I have been presented with a copy of the *Notice of Privacy Practices* for Spring Integrative Health, PLLC detailing how my information may be used and disclosed as permitted under federal and state law and that I have read and understand such Notice.

Interoffice Collaborative Care Release Purpose

Purpose: This purpose of this form is to obtain your permission for independent healthcare practitioners working at the Spring Integrative Health facility, but who are not employees of Spring Integrative Health, PLLC to have access to your

health information solely for the purpose of your treatment and care. The practitioners at Spring Integrative Health often work in collaboration to best serve their patients. All healthcare providers working at the Spring Integrative Health facility use a shared electronic medical records system; however, providers will only access your records if they have a need to do so for your treatment purposes, and all providers follow the Spring Integrative Health's HIPAA Privacy Practices.

By checking the spaces below, I authorize practitioners/physicians working at Spring Integrative Health whom I have seen as a patient to collaborate on my behalf with other practitioners at the facility for my care and to share my health information in order to do so. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. I understand that I am entitled to a copy of this authorization form at the time of signing.

All medical record needed for collaborative care including:

- Diagnostic imaging reports and pathology reports
- Laboratory reports
- Chart notes

I understand that certain information in these records cannot be release without specific authorization because of federal or state laws. By checking the spaces below (HIV, DRUG/ALCOHOL, MENTAL HEALTH), I specifically authorize the release of the following confidential information for use by practitioners/physicians at Spring Integrative Health whom I have seen as a patient.

8. Changes to This Privacy Policy

We may update this Privacy Policy periodically to reflect changes in our practices, legal requirements, or services. Any changes will be posted on this page with an updated effective date. We encourage you to review this Privacy Policy regularly to stay informed about how we are protecting your information.

9. Contact Us

If you have any questions, concerns, or requests related to this Privacy Policy or our use of your personal information, please contact us at:

Spring Integrative Health

reception@springintegrativehealth.com

406-586-2626

962 Stoneridge Drive, Suite 2. Bozeman, MT 59718

Authorization to Leave Messages

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to request that communications concerning your personal health information be made through confidential channels. The purpose of this document is to give the staff of Spring Integrative Health permission to leave certain health information on your phone messaging service or other form of communication. We will not ask you why you are making your request and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and, as appropriate, information as to how payment will be handled.

Signature and Date for PATIENT COMMUNICATIONS POLICY *

Signature and Date for FINANCIAL AND CANCELLATION POLICIES*

Signature and Date for CREDIT CARD AUTHORIZATION*

CREDIT CARD INFORMATION--CARD HOLDER NAME*

CREDIT CARD INFORMATION--CARD HOLDER BILLING ADDRESS*

CREDIT CARD INFORMATION--CARD TYPE*

CREDIT CARD INFORMATION--CARD NUMBER*

CREDIT CARD INFORMATION--CARD EXPIRATION DATE*

CREDIT CARD CWW number *

Signature and Date for CONSENT TO TREATMENT*

Signature and Date for INFORMED CONSENT for TELEMEDICINE and AI charting assistant*

Signature and Date for NOTICE OF PRIVACY PRACTICES*

Signature and Date for Interoffice Collaborative Care *

Signature and Date for Authorization to Leave messages and Texts*

I authorize my practitioners/physicians at Spring Integrative Health to use the following information to collaborate on my behalf and for my benefit in holistic medical care to achieve the best possible outcomes:*

☐ YES
☐ NO

All other practitioners/physicians at Spring Integrative Health are allowed authorization to review these medical records: HIV/AIDS test results and related information, including high risk behavior documentation. *

☐ This information may NOT be further disclosed without the specific written authorization of the tested individual.
☐ This information MAY be further disclosed without the specific written authorization of the tested individual.

All other practitioners/physicians at Spring Integrative Health are allowed authorization to review these medical records: Drug /Alcohol diagnosis, treatment, or referral Information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information:

All other practitioners/physicians at Spring Integrative Health are allowed authorization to review these medical records:
Mental Health treatment information*

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Signature for acknowledgement for AUTHORIZATION TO LEAVE MESSAGES *

I hereby request the use of the following method for the communication of information related to my personal health and treatment, such as test results, appointment reminders and detailed treatment instructions, or payment for treatment.

Please select all that apply.*

- ☐ I want you to contact me by telephone at the phone number listed above.
- ☐ You can leave messages on my answering machine or voicemail.
- ☐ Do NOT leave messages on my answering machine or voicemail.
- ☐ Mail: You may contact me by mail at the address listed above.

Signature
