LHC Group, Inc. Notice of Privacy Practices

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

LHC Group, Inc. and its affiliated companies (the "Provider") (collectively, an "Affiliated Covered Entity"), may use and disclose your protected health information for treatment, payment, health care operations and as required by law in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), and the HIPAA Omnibus Rule (Collectively, the "HIPAA Rules"). The use of "you" or "your" below, also refers to your authorized representative(s). The terms "information" or "health information" in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

CONSENTS: In accordance with the HIPAA Rules, the Provider exercises its option to obtain your consent regarding the use and disclosure of your information at the start of care or within a reasonable amount of time afterwards. The Provider retains the right not to provide treatment if you refuse to sign the consent form.

AUTHORIZATIONS: Your written authorization is required for the disclosure of your protected health information when the disclosure is not for treatment purposes, health care operations or payment, or required by law.

YOUR HEALTH INFORMATION MAY BE COLLECTED, USED & DISCLOSED WITHOUT PATIENT AUTHORIZATION:

To Provide Treatment. The Provider and others involved with treatment (such as your attending physician, family members, pharmacists, suppliers of medical equipment or other health care professionals) may disclose your health information to each other to provide appropriate treatment to you. For example, your attending physician needs information about your symptoms in order to prescribe appropriate medications. Where applicable, any documents containing protected health information given to you or left in your home/place of service by one of our caregivers for the purpose of treatment and/or continued care, is your responsibility to safeguard.

To Obtain Payment. The Provider may disclose your health information to collect payment from third parties. For example, the Provider may be required by your health insurer to disclose information regarding your health care status to obtain prior approval for treatment.

To Conduct Health Care Operations. The Provider may disclose your health information as necessary to facilitate the Provider's health care operations and to provide quality care to all of the Provider's patients, including such activities as:

- Quality assessment, improvement, and patient safety activities
- Activities designed to improve health or reduce health care costs
- Protocol development, case management and care coordination
- Contacting providers and patients about treatment alternatives and other related functions
- Professional review and performance evaluation
- Supervised professional training programs
- Accreditation, certification, licensing or credentialing
- Reviews and auditing (includes compliance, medical, and legal services)
- Business planning, development (includes cost management, analyses, formularies), management and general administration

For example, the Provider may use your health information to evaluate its staff performance, combine your health information with other Provider patients in evaluating how to more effectively serve all Provider patients, disclose your health information to Provider staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you via information mailings (unless you tell us you do not want to be contacted for such).

To Provide You Reminders and Communication. The Provider may send you reminders about your care, such as appointment reminders. The Provider may communicate treatment, payment, or health care operations using telephone numbers or email addresses you provide to us.

To an Affiliated Covered Entity: The Provider may disclose information to other affiliated entities that are part of the Affiliated Covered Entity to carry out treatment, payment and health care operations as described above, which may include assisting to identify and provide appropriate care for you or to assist in administrative functions related to your care.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to, or perform functions on behalf of, the Provider. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates and their subcontractors are required by law to safeguard your protected health information.

To Health Information Exchange (HIE) (for all states except the state(s) listed below). Providers may participate in electronic health exchanges (HIE) and may share your health information as described in this Notice. A HIE is a way of sharing your health information among providers such as hospitals, doctors, labs and other health care providers through secure, electronic means. As permitted by law, your health information will automatically be shared with this exchange to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. If you wish to opt-out, please contact your provider, call 1-800-489-1307, or email hie.consent@lhcgroup.com;

In Maryland: We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a regional health information exchange serving Maryland. As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public Health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers. We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.

As Required by Law (for all states except the state(s) listed below). There are federal and state regulations that require certain reporting, including population-based activities relating to improving health or reducing health care costs. For example, your health information may be required for public health activities, abuse, neglect or domestic violence investigations, law enforcement purposes, specialized government functions, military/veterans affairs, death related functions/purposes, organ and tissue procurements/donations, to avert a serious threat to health or safety, judicial and administrative proceedings, disaster relief and workers compensation. Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information; including alcohol/substance use disorder, biometric, child or adult abuse or neglect, including sexual assault, communicable diseases, genetic, HIV/AIDS, mental health, minors, prescriptions, reproductive health or sexual health and sexually transmitted diseases. If the state privacy laws are more stringent than federal privacy laws, the state law overrides the federal law.

We follow the more stringent or protective law, where it applies to us. For example, if we receive information about you through a limited consent you provided to a federally-assisted substance use disorder treatment program ("Part 2 Program"), we will honor the permission you provide and continue to comply with 42 CFR Part 2. If your consent permits our use and disclosure for all future treatment, payment and health care operations purposes, we may use or disclose that information for those purposes and otherwise use and disclose that information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In no event will we use or disclose your Part 2 Program information in legal proceedings against you without your written consent or a court order after you have been notified and provided an opportunity to be heard.

Other than as stated above, the Provider will not disclose your health information without your written authorization, which you may revoke in writing at any time.

In Nevada: **Notice to Patients Regarding Access to Health Care Records.** Your health care records may be accessed by the Board in accordance with NRS 630.139.

WRITTEN AUTHORIZATION IS REQUIRED OUTSIDE OF TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, OR AS REQUIRED BY LAW FOR THE FOLLOWING:

- Litigation
- Life insurance
- Fundraising/Marketing
- Psychotherapy notes/records
  Substance abuse disorder records
- Disability
- Research
  HIV or Genetic testing Results

WITH RESPECT TO YOUR HEALTH INFORMATION, YOU HAVE THE RIGHT:

- **To request restrictions** on certain uses and disclosures of your health information for treatment, payment, or health care operations. You also have a right to restrict disclosure to individuals involved in your care or payment. Any request for restrictions must be made in writing. Please note that while we try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for restriction except where you have paid for an item or service in full out-of-pocket and request that we not disclose information about that item or service to your health plan. If we do agree with your request for restrictions, we will honor your limits unless it is an emergency situation.

- **To receive confidential communications in a certain way**. For example, you may request that the Provider only communicate with you privately with no other family members present. The Provider will not request any reasons for your request and will attempt to honor any reasonable requests. If you would like to ask for an alternate means of communication, please request an Alternate Confidential Communication Form to document how you wish to receive confidential communications.

- **To inspect and receive a copy of your health information** including billing records. To request an inspection or copy of your records containing your health information, please directly notify your Provider. You may request to receive this information in electronic or paper format. The Provider may charge a reasonable fee for copying and assembling costs associated with your request. Federal regulations require that we provide a copy of the clinical record to home health patients at no charge. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. Federal regulations require that we provide a copy or a summary of your home health and claims records upon the next visit after the request or within 4 days of your request, whichever comes first.

- **To request amendments to your health care information** (including corrections or other opinions) for any health information in question for as long as it is maintained by the Provider. This right does not include the deletion, removal, or erasure of health information. All such requests must be made in writing. The Provider may deny the request if: (a) the request is not in writing; (b) the request does not include a reason; (c) the health information was not created by the Provider nor part of the Provider's records; (d) if you are not otherwise permitted by the Regulations to inspect or copy the health information in question; or, (e) if after considering your request, the Provider finds that your health information is already accurate and complete. We may say "no" to your request, but we will tell you why in writing within 60 days.

- **To an accounting of disclosures** of your health information made by the Provider for reasons other than for treatment, payment or health care operations. All such requests must be made in writing and should specify the time-period for the accounting not to exceed six (6) years or the normal record retention policy of the Provider, whichever is longer. The Provider will provide the first accounting requested during any twelve (12) month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

- **To get a paper copy of this Notice** at any time even if you have received this Notice previously. A copy of the current version of this Notice is available at the Provider location and at www.lhcgroup.com.

- **To choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **In certain states, you may have the right to withhold written consent to the disclosure of reproductive health care services information in certain cases.** Depending on your state of residence, we may be required to obtain your written consent before releasing information about your reproductive health care services in certain civil actions or proceedings, subject to some exceptions. In such cases where we are required to obtain your consent, you have the right to withhold your consent.

To exercise any of your rights described above, mail your written request to the Privacy Officer at the address listed at the bottom of this notice.

DUTIES OF THE PROVIDER (AS REQUIRED BY LAW):

- to maintain the privacy of your health information;
- to maintain physical, electronic, and procedural security safeguards in the handling and maintenance of your information, to protect against risks such as loss, destruction, or misuse;
- to provide to you or your representative this Notice of its duties and privacy practices;
- to abide by the terms of this Notice as may be amended from time to time; and
- to notify you in the event that we or one of our Business Associates discover a breach of your unsecured protected health information, in a manner not permitted under the HIPAA Rules, which compromises the security or privacy of your protected health information, unless after assessment it is determined that there is a low probability that the protected health information was compromised.

CHANGES TO THIS NOTICE: The Provider reserves the right to change the terms of this Notice and to make such changes effective for all health information that it maintains. If the Provider changes this Notice, the Provider will provide a copy of the revised Notice to you via your Provider location (and at www.lhcgoup.com).

COMPLAINTS/GRIEVANCES: You have the right to express complaints or file grievances to the Provider or the Secretary of DHHS if you believe that your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint.

TO CONTACT US: Privacy and security concerns related to your patient information can be addressed directly to your Provider, or our designated **HIPAA Privacy Officer at 1-800-489-1307, or by the direct mailing address below:**

Privacy Officer
LHC Group, Inc.
901 Hugh Wallis Road South
Lafayette, LA 70508

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Notice of Availability of Language Assistance Services and Alternative Formats

ATTENTION: If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Contact the provider for assistance.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición.. Comuníquese con el proveedor para obtener ayuda.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。请联系服务提供商寻求帮助

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Liên hệ với nhà cung cấp để được hỗ trợ.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.
도움이 필요하시면 서비스 제공업체에 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. makipag-ugnayan sa provider para sa tulong

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Обратитесь к поставщику услуг за помощью.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ
.اتصل بمقدم الخدمة للحصول على المساعدة

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Kontakte founisè a pou asistans.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Contactez le fournisseur pour obtenir de l'aide.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy skontaktować się z dostawcą w celu uzyskania pomocy.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Contate o fornecedor para obter assistência.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Contatta il fornitore per ricevere assistenza.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich an den Anbieter, um Unterstützung zu erhalten.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。プロバイダー（に）連絡してください」

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
.برای کمک با ارائه دهنده تماس بگیرید

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें सहायता के लिए सेवा प्रदाता से संपर्क करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Tiv tauj koj tus kws muab kev saib xyuas kom tau kev pab.

ចំណាប់អារម្មណ៍៖ បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Camodian-Mon-Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ សូមទាក់ទងអ្នកផ្តល់សេវាដើម្បីសុំជំនួយ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Makisarita iti mangipaay ti tulong.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. Kééhółníihii bich'į' aná'álwo'ígíí bich'į' kóníłchíih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. la xidhiidh bixiyaha si aad gargaar u hesho.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. επικοινωνήστε με τον πάροχο για βοήθεια.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે. સહાય માટે પ્રદાતાનો સંપર્ક કરો.

УВАГА: Якщо ви розмовляєте **українською мовою (Ukrainian)**, у вас є можливість скористатися безкоштовними послугами перекладача.
Зверніться до провайдера за допомогою.

AADACHT: Wann du **Deitsch Schwetze (Pennsylvanian Dutch)** kann, kannscht du frei Schprooch aushilfe griege. Ruf dei provider (oder Gidder) fer Helf an.

FAAALIGA: Afai e te tautala Faa-**Samoa (Samoan)**, o loo avanoa tautua mo fesoasoani tau gagana mo oe, e le totogia. Fa'afeso'ota'i le kamupani mo se fesoasoani.