

THE GENEVA SUITES
NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: January 1st, 2016

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.

I. Our Duty to Safeguard Your Protected Health Information

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

What is Protected Health Information?

Protected Health Information is individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for the health care treatment or services you receive including demographic information such as your name, address, and birth date. As such, we are required to provide you with this Privacy Notice that contains information regarding our privacy practices that explains how, when and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures.

Except in regards to treatment or certain other specified circumstances, we must use or disclose only the minimum necessary protected health information to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will post a copy of the new/revised Privacy Notice. You also may request and obtain a copy of any new/revised Privacy Notice from the Administrator, Scott Hemenway at 612-208-8888 or by email at scott@TheGenevaSuites.com.

We will notify you in writing of a breach of your unsecured protected health information should one occur.

II. How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. The following sections list different ways that we use and disclose health information about you. The privacy law lets us make some uses or disclosures of your protected health information without your consent or authorization. We can use and/or disclose your health information for purposes of treatment, payment, or for the operations of our facility. We can also use or disclose your health information without your permission if it is required by state or federal laws. For other uses, we must get your written permission to use or give out your protected health information.

Should it become necessary to share your protected health information to an outside party that qualifies as a business associate, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The following sections list different ways that we may use or disclose your protected health information for treatment, payment and health care operations.

For Treatment:

We may use your protected health information to provide your health care. We may use or disclose your protected health information to those who are involved in providing care to you such as physicians, nurses, nursing assistants, or other staff involved in taking care of you. For example, different healthcare providers within this facility may share information about you to coordinate things you need such as prescriptions or special meals. We may also disclose health information about you to outside healthcare providers performing services relating to your treatment such as a specialist, diagnostic laboratories, or home health/hospice agencies. We give this information about your care and treatment so they have information about you to coordinate your care.

For Payment:

We may use or disclose your protected health information to bill and collect payment from you, the responsible party, Medicare, Medicaid or other government programs, insurance companies, or a third party for services or treatments we provided to you. We may also disclose your protected health information to other covered entities or healthcare providers for payment activities of those entities or providers. For example, we may need to send information to your insurance company, providers, health plan, or another third party to obtain payment for services we provided to you.

For Health Care Operations:

We may use or disclose your protected health information to perform certain functions within our facility. These uses or disclosures are necessary to run our facility and make sure that you and all others we provide care and services to continue to receive quality care and services. For example, we may take your photograph for medication identification purposes or use your health information to evaluate the effectiveness of the care and services you are receiving. We may disclose your protected health information to our staff (nurses, nursing assistants, physicians, staff consultants, therapists, volunteers, etc.) for auditing, quality assurance and improvement activities, and learning purposes. We may also combine your health information with information from other health care providers to study how our facility is performing in comparison to like facilities or what we can do to improve the care and services we provide to you. When information is combined, on occasion if such information will be shared with others, we remove all information that would identify you so that others may use the information in developing research on the delivery of health care services without learning your identity. We may also disclose your protected health information under certain circumstances to other covered entities for activities related to certain quality assurance related activities or detection of fraud or abuse.

Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

Certain state and federal laws and regulations either require or let us use or disclose your protected health information without your consent or authorization. The uses or disclosures we may make without your consent or authorization include the following:

Required by Law and For Judicial and Administrative Proceedings:

We may disclose your protected health information when a federal, state or local law requires that we report information about suspected abuse, neglect, or domestic violence, reporting adverse reactions to medications or injury from a health care product, or in a judicial or administrative proceeding in response to a court order or subpoena, or as otherwise permitted or required by law. We may also disclose your protected health information for certain limited purposes involving law enforcement.

Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability:

We may disclose your protected health information when we are required to collect information about diseases or injuries (e.g., your exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recalls (e.g. reactions to medications or problems with products), or to report vital statistics (e.g., births/deaths) to the public health authority).

Health Oversight Activities:

We may disclose your protected health information to a health oversight agency such as a protection and advocacy agency, the state agency responsible for inspecting our facility or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations and civil rights issues.

Workers Compensation:

We may disclose your protected health information in order to provide workers compensation benefits.

To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:

We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your health information to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties. If you are an organ or tissue donor, we may disclose your protected health information to the organization that will handle your organ donation or transplantation.

For Research Purposes:

We may disclose your protected health information for research purposes only when a privacy board has approved the research project. However, we may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researchers identifying persons to be included in the research project will be required to conduct all activities onsite. If it becomes necessary to use or disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information.

To Avert a Serious Threat to Health or Safety:

We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others.

Specific Government Functions:

We may disclose protected health information of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities (such as protection of the President), or to correctional institutions.

For Fundraising Activities:

We may use a limited amount of your protected health information when raising money for our facility and its operations. We may also disclose this information to a foundation related to the facility so that the foundation may contact you to raise money on behalf of our facility. The information we may use will be limited to your name, address, telephone number (and those of your primary contact), and dates for which you received treatment or services at our facility. You have the right to opt out of receiving fundraising communications. To opt out, you may notify the facility's HIPAA Contact person that you do not wish to receive these communications. Any fundraising communication will also provide you information regarding the process for opting out.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services:

The facility may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may use or disclose your protected health information for purposes of contacting you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you. For example, a newly released medication or treatment that has a direct relationship to the treatment or medical condition.

Uses or Disclosures of Your Protected Health Information After You Have A Chance to Object

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance opportunity to object to such release or if such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (because you were not present or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so. If you object to disclosure of the following information, please contact the HIPAA Contact person listed on the first page of this document.

Facility Directory:

We may use or disclose your name, unit or room number, and religious affiliation in our facility directory. We may only disclose your religious affiliation to a member of the clergy. Information concerning your general condition or room location may be provided to callers or visitors when they ask for you by name.

Information Disclosed to Family Members, Friends or Others Involved in Your Care:

We may disclose your protected health information to your family members and friends who are involved in your care or who help pay for your care. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (i.e., alive or dead).

Uses and Disclosures Requiring Your Written Authorization

For other uses and disclosures of your protected health information not covered by this notice, beyond treatment, payment, health care operations or laws that apply to us, we are required to have your written authorization. For example, disclosures requiring an authorization include psychotherapy notes, marketing communications, and sale of your protected health information, unless otherwise authorized by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization or if the authorization was obtained as a condition of obtaining insurance coverage. Your revocation request must be provided to us in writing.

III. Your Rights Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain on our premises:

To Request Restrictions on Uses and Disclosures of Your Protected Health Information:

You have the right to request that we limit how we use or disclose your protected health information for treatment, payment or health care operations. For example, you could request that we not disclose to family members or friends information about a medical treatment you received. **We are not required to agree to your restriction request.** However, should we agree, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you, or unless the restriction is appropriately terminated.

Upon your written request, we are required to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and the protected health information pertains solely to a health care item or service for which you, or a person other than the health plan on behalf of you, has paid us in full.

The Right to Inspect and Copy Your Medical and Billing Records:

With some exceptions, you have the right to inspect and copy your health information, such as your medical and billing records that we use to make decisions about your care and services. In order to inspect and/or copy your health information, you must submit a written request to us. If you request a copy of your medical information, we may charge you a reasonable fee for the paper, labor for copying and mailing, mailing costs, or any agreed upon costs of preparing an explanation or summary involved in filing your requests. If we maintain electronic records of your protected health information, you have the right to receive this information in electronic form if it is readily producible, or in an electronic form as agreed to by you and the facility.

The Right to Amend or Correct Your Health Information:

You have the right to request that your health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us for as long as we maintain/retain your health information. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections. We may deny your request if:

- a. Your request is not submitted in writing;
- b. Your written request does not contain a reason to support your request;

- c. The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- d. It is not a part of the health information kept by or for our facility;
- e. It is not part of the information which you would be permitted to inspect and copy; and/or
- f. The information is already accurate and complete.

If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response you may have relative to the information and denial process appended to your health information.

The Right to Request Confidential Communications:

You have the right to request that we communicate with you about your health matters in a certain way or to a certain location. For example, you may request that we only send health information about you to a specific address. We will agree to your request as long as it is reasonable for us to do so. You are not required to reveal nor will we ask the reason for your request. To request confidential communications you must notify us in writing.

The Right to Request an Accounting of Disclosures of Protected Health Information:

You have the right to request that we provide you with a listing of when, to whom, for what purpose, and what content of your protected health information we have released over a specified period of time. This accounting will not include any information concerning disclosures we have made for the purposes of treatment, payment, or health care operations or information released to you, your family, or the facility directory, disclosures made for national security purposes, or any releases pursuant to your authorization. Your request must be submitted to us in writing and must indicate the time period for which you wish the information. Your request may not include releases for more than six (6) years **prior** to the date of your request. Your request must indicate in what form (e.g., printed copy or email) you wish to receive this information. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period.

The Right to Receive a Paper Copy of This Notice:

You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at anytime or you may obtain a copy of this information from our website. You may obtain a paper copy of this notice from our Administrator.

IV. How to File a Complaint About Our Privacy Practices

If you have reason to believe that we have violated your privacy rights, violated our privacy policies and procedures, or you disagree with a decision we made concerning access to your protected health information, etc., you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way if you file a complaint. To file a complaint with the Department of Health and Human Services you may contact:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Toll Free 1-877-696-6775

To file a complaint with us, or for additional information about our privacy practices, please contact our Administrator below.

Scott Hemenway
The Geneva Suites
12207 Wood Lake Drive
Burnsville, MN 55337
Phone: (612) 208-8888
Fax: 952-891-8100
Email: scott@TheGenevaSuites.com

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

RESIDENT/TENANT NAME: _____
(Print or Type Resident/Tenant's Name)

For Signature By Resident/Tenant or Resident/Tenant's Responsible Party (Please Sign and Return Immediately in the Enclosed Self-Addressed Envelope):

By signing below, I acknowledge receipt of Facility's current Notice of Privacy Practices on the date of (_____).

(Resident/Tenant)

(Responsible Party)*

(Responsible Party includes legal representative, guardian, conservator, attorney in fact under power of attorney, and designated responsible party acting on the Resident/Tenant's behalf.)

For Completion By Facility:

If Resident/Tenant or Responsible Party fails to sign this Receipt of Notice of Privacy Practices, a Facility Representative shall complete the following by initialing/dating and providing additional information where appropriate:

Facility provided its Notice of Privacy Practices to {select one of the following by circling the appropriate choice} (Resident/Tenant) or (Responsible Party) or (_____) by mail sent on or before the Resident/Tenant's first date of service, and

_____/_____. The person to whom the Notice of Privacy Practices was given, as identified above, refused to sign and return the Acknowledgment after being requested to do so.

OR

_____/_____. The written Acknowledgement of Receipt of Facility's Notice of Privacy Practices was not obtained for the following other reasons:

_____.