New Patient Registration

Patient Information: **Date:**

Note: Please spell name exactly as spelled on your insurance card

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name:_____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

DOB: _____ Age: _____ SSN:_____

Gender: _____ Identifies As:_____ Marital Status:_____

Primary Language: _____Interpreter Needed: Y or N

Ethnicity: (*Please check one)*

Native American ___ African American ___ Latino ___ Asian ___ Pacific ___ Caucasian ___ Other: _____Choose not to disclose ☐

Employer: _____ Occupation: _____

Employer Address: _____ Phone Number: _____

Emergency Contact: ***The person you would like us to notify in case of emergency.***

Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Parent(s)/Guardian(s)/Spouse:

Note: If divorced, please supply Pearl Health Clinic with legal documentation of custody to ensure that privacy rights can be followed.

Full Name: _____ DOB: _____ SSN: _____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____Employer Phone: _____

Full Name: _____ DOB: _____ SSN: _____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____Employer Phone: _____

Is there a custody arrangement for your child? * Yes or No If yes, please describe _____

Please check box and initial, if it is ok to communicate with you regarding the following via

☐Appointment Message _____ ☐ Clinical Message _____ ☐ Financial Message _____

For Administrative Use Only:

Date Received: _____ Copy of new insurance card: _____ Staff Initials: _____

Patient Name:
Account Number:

Medical Information

**Please note that Case Managers should accompany developmentally or severely mentally ill clients. **

Patient's Primary Care Physician: _____ Phone Number: _____Most recent visit: _____

Pharmacy: _____ Address: _____Phone: _____

Medical History: (High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, Etc.)

Surgical History: Check if None ☐

Medication Allergies: Check if None ☐

Current Prescription Medications: Check if None☐
Name/Dose/#tablets per day, times taken per day

Over the counter medications:
(Aspirin, Tylenol, Vitamins, etc.)

Family History: (Medical Illnesses, Surgeries)

Social History:

Smoke: Y N If yes, how much: _____# packs per day _____ # of years

Alcohol: Y N If yes, how much: _____

If receiving mental health service from another facility, please list them below:

Location: _____Case Manager Phone Number: _____

Services: (i.e. counseling, med mgt, case management, CBRS, etc.)

Reason for being seen at Pearl: _____

Name of Referring Provider: _____

Services Requested: **Please check all services that the patient is interested in**

- ☐ **Adolescent Mental Health Intensive Outpatient** – IOP (for ages 13-17) is an intensive program with an emphasis on group therapy. Individual and family therapy, medication management, and case management are also included. The Adolescent program requires 6 hours of service per week. The average admission lasts 3 months.
- ☐ **Case Management** – Assists people with mental illnesses in obtaining the basic services required to live as independently as possible in their communities. The goal is to ensure an individual is receiving the support they need while working to increase the individual's ability for self-support. (Medicaid Insurance Only)
- ☐ **Community Based Rehabilitation Services (CBRS)** – CBRS assists individuals to gain and utilize skills necessary to function adaptively in home and community settings and attain or retain capability for independence. (Medicaid Insurance Only)
- ☐ **Counseling** – A relatively short term, interpersonal, theory-based process of helping persons who are basically psychologically healthy but need help in resolving developmental and situational problems.
- ☐ **EMDR Therapy** – Eye Movement Desensitization and Reprocessing (EMDR) therapy is an interactive psychotherapy technique used to relieve psychological stress.
- ☐ **Family Support** – A parent or care giver who has cared for a child with severe emotional disorders and has successfully navigated the system. This service helps to engage the family in their own strengths and be able to make their family the best it can be.
- ☐ **Medication-Assisted Treatment (MAT) for Substance Use Disorder** – The use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach for the treatment of substance use disorders. Medications such as Suboxone are used and have been approved by the Food and Drug Administration (FDA). Medication-assisted treatment has been shown to help patients successfully obtain and maintain sobriety from opioids.
- ☐ **Neuro-feedback Therapy** – A non-invasive alternative way of improving your quality of life. The electrical activity of your brain is monitored through a software program that lets you, the client; see the activity of your brain on a monitor.
- ☐ **Neuropsychological/Psychological Testing** – Measure and evaluate neuropsychological factors, such as memory, and psychological factors, such as personality. Testing aids in diagnosing conditions such as developmental disability, dementia, and personality disorder. It helps differentiate between diagnoses, such as ADHD and bipolar. Testing aids in developing treatment plans.
- ☐ **Peer Support** – An individual, with related mental health experiences, who is specialized to support individuals who struggle with issues pertaining to mental health, psychological trauma, and/or substance abuse. (MUST BE 18 OR OLDER AND MUST HAVE MEDICAID)
- ☐ **Psychiatric Medicine** – Psychiatry is the medical specialty devoted to the study, diagnosis, treatment, and prevention of mental disorders. These include various affective, behavioral, cognitive and perceptual abnormalities.
- ☐ **Respite Care** – A service that provides a break for parents who have a child with a serious emotional disturbance. Trained behavioral health workers take care of the child for a brief period of time to give families relief from the strain of caring for the child. Is there a specific medical provider or counselor you would like to request?
- ☐ **Spravato** – a treatment resistant treatment for depression, and depression with suicidal ideations; it is an enantiomer of Ketamine, administered via nasal spray. The treatments are 2 hours long, where the patient is monitored for elevated blood pressure, dissociation, and sedation. Patients who undergo treatment must secure rides to and from the facility and cannot drive the rest of the day following their treatment.
- ☐ **Skills Training and Development (STAD)** – Treatment for members whose functioning is sufficiently disrupted to the extent that it interferes with their daily life. Skills training and development is provided as group activities focusing on enhancing and/or developing social, communication, behavior, coping, and basic living skills.
- ☐ **Substance Abuse Program** – This outpatient program involves weekly group therapy sessions, weekly, biweekly or monthly individualized counseling as determined by treatment plan, and regular medication management appointments
- ☐ **Targeted Care Coordinator (TCC)** – assists the child and family locate, coordinate, facilitate, link advocate and monitor the services identified through assessment of needs to help then reach their goals.
- ☐ **Transcranial Magnetic Stimulation** – Transcranial Magnetic Stimulation is a safe and effective, non-drug depression treatment. Patients receive treatment 5 days per week, usually for 4 to 6 weeks.

Is there a specific medical provider or counselor you would like to request to see? _____

What to expect on your first appointment?

1. Children 17 and younger need to be accompanied by a Parent and / or Legal Guardian. **NO EXCEPTIONS**
2. Please arrive 15 minutes prior for new patient appointments.

New Patients' will be scheduled for a Comprehensive Diagnostic Assessment (CDA) which is approximately 1 ½ hours in duration, with a Licensed Mental Health Counselor. This appointment is a set of evaluation procedures administered to obtain information about the person's development, learning, memory, academics, behavior, and mental health. This assessment is vital in allowing your provider(s) the ability to establish an accurate treatment plan.

Legal Services Disclaimer:

_____*(initial)*Pearl Health Clinic staff does not complete parental fitness or custody exams. Assessments for legal purposes are typically not covered by most insurance companies and are associated with a fee schedule separate from the mental health fee schedule. All requests for services in legal contexts will be reviewed and may be declined at the discretion of the Pearl Health Clinic Clinical Director or individual clinicians. Pearl Health Clinic staff charge for any testimony provided in a legal context, even when original services were rendered as part of mental health treatment.

Appointment Cancelation/No Show Policy and Fee

_____ (initial)** **Effective 1/1/2023, any client who cancels an appointment within 3 hours of the scheduled appointment or fails to arrive within 15 minutes of the appointment time is considered a "no-show."** If you do not cancel or reschedule your appointment with at least 3-hour notice, we may assess a $25.00 "No Show" service charge to your account. This "No Show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three (3) consecutive No Shows, Pearl Health Clinic may decide to end its relationship with you and you will need to transfer care to another provider.

Consent for Student to attend appointment. *(Please select one)*

_____(initial) Yes, I give consent for student to participate in my appointment.

_____(initial) No, I do not give consent for student to participate in my appointment.

How did you hear about Pearl Health Clinic? *(Please select one)*

☐Primary Care Doctor ☐Relative ☐Friend ☐Community Event ☐Website ☐ social media ☐Newspaper

☐Other: _____

Preferred Location: *(Please select one)*

☐Ammon Location ☐Idaho Falls Location ☐Pocatello Location ☐Rexburg Location

Printed Name of Parent/Guardian (if under 18 years of age): _____ **Relation:** _____

Signature of Patient or Parent/Guardian of Patient: _____ **Date:** _____

Insurance Information and Authorization to Bill Insurance

Insurance Information

Patient Name: _____ **DOB:** _____

Primary Insurance: _____

Insurance Policy Number: _____ Insurance Group Number: _____

Policy Holder: _____ Phone: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ Employer: _____ Employer Phone: _____

Policy Holder's Address: _____

Secondary Insurance: _____

Insurance Policy Number: _____ Insurance Group Number: _____

Policy Holder: _____ Phone: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ Employer: _____ Employer Phone: _____

Policy Holder's Address: _____

If you are concerned about the cost of services at Pearl Health Clinic, please contact our Billing Office directly to discuss payment options. To apply for a Sliding Scale, a discount applied to your const of services based upon your family size and income compared to the Federal Poverty Guidelines, please go to our website at https://pearlhealth.org/clients/financial-assistance/ and complete the Sliding Scale Application or speak with our Billing Office for Assistance.

Release to Bill Insurance for Services

PHC is a contracting provider with most insurance carriers, and we will bill your insurance accordingly. We will do everything we can to aid you in receiving the maximum allowable benefits from your insurance carrier; however, you are ultimately responsible for your account. This includes any unpaid balances, after contractual adjustments (if applicable). Providing PHC with current and accurate insurance information will allow us to obtain the quickest response from your insurance. Your insurance may not cover services at the same rates as other participating providers. Some insurance plans require that the patient contact them for Prior Authorization. Failure to contact them, as required, may result in you being responsible for the full amount of your charges.

For Minor Patients or those with Legal Guardians: The Parent/Guardian and/or Guarantor is responsible for the payment (and all balances due), at the time of treatment. Unaccompanied Minors MUST have pre-authorization, from the Parent/Guardian. Please note that statements will only be sent to the Responsible Party, as indicated on the Patient's Intake. If you have a credit balance, a refund check will be issued to you immediately. **For plan Specific information, please contact your insurance carrier, directly.*

ASSIGNMENT AND RELEASE

_____ (initial)**Non-Medicare**: I hereby assign my insurance benefits, to be paid directly to Pearl Health Clinic. I understand that I am financially responsible for any non-covered services (including those with MEDICAID). I also authorize Pearl Health clinic to release any information required to process my claims.

_____(initial) **Medicare/Medicare Advantage Plans**: I request the payment of authorized Medicare benefits to be made on my behalf to Pearl Health Clinic. This payment should include payments for services provided to me, by Pearl Health Clinic and its affiliate Providers. I authorize the release of my personal medical information, to the Centers for Medicare and Medicaid Service (CMS) and its agents. The release of said information shall be used to determine benefits or the benefits payable for related services. This authorization is effective until I choose to revoke it, in writing. Standard Medicare patients are required to sign an annual ABN notice.

Printed Name of Parent/Guardian (if under 18 years of age): _____ **Relation:** _____

Signature of Patient or Parent/Guardian of Patient: _____ **Date:** _____

INFORMED CONSENT

TO TREAT AND TO USE AND TO DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT

By signing this form, you agree to our "Notice of Privacy Practice". The patient or parent/guardian consents and authorizes Pearl Health Clinic to provide treatment. Failure to sign this form will terminate all services provided at Pearl Health Clinic. This form constitutes an agreement between, _____and Pearl Health Clinic. Hereafter, the patient will be referred to as "you" or "your".

(Patient Name)

Reason for Consent

Pearl Health Clinic is committed to providing the highest quality of care. For this reason, we coordinate care with your Primary Care Physicians, insurance provider, government entities, pharmacy databases, and others pertinent to your treatment. When we examine, diagnose, treat, or refer you to another provider, we will be collecting/sharing Protective Health Information (PHI) about you. This information is used to decide what treatment(s) are best for you and to provide treatment(s) to you. Understand that many treatment options provided at Pearl Health Clinic also require that we pre-authorize that service or treatment before we begin the specified treatment. Not having current and accurate information can delay those services or result in those services being denied. Policies and agreements highlighted in this informed consent, Primary Care Physician, Mandated reporting requirements, Client Rights, and Prescription History. Please refer to the "Notice of Privacy Practice" to get further detail or clarification. If you do not have a copy, you can obtain one with our Front Office Staff or online at www.pearlhealth.org. These policies are susceptible to change and as these changes occur, so may our "Notice of Privacy Practice". Changes will be updated as needed.

Primary Care Physician

You consent to the exchange of your protected health information between Pearl Health Clinic and your Primary Care Physician (PCP).

_____

(PCP Name) *(PCP Phone Number)*

Mandated Reporting

Treatment providers and staff are mandated reporters. We are required by law to report a "reasonable suspicion" for threats of harm against yourself or others to the appropriate authorities and persons of interest.

Client Rights

You have the right to request Pearl Health Clinic and its staff to not disclose information regarding treatment, payment, and/or administrative purposes. Requests must be made in writing with dates and signatures. PHC will make every effort to respect your requests, however, PHC retains the right to determine the appropriateness of the requests as PHC is compelled to follow HIPAA laws as well as other state and federal regulations. Processing claims and mandated reporting requirements are examples of requests that will be rejected. You have the right to revoke this consent at any time. This must be submitted in writing and will be processed through the Reception Staff. Disclosure of your information will cease, effective the date of the letter revoking consent. Any information disclosed on or before revoking consent, cannot be changed. Please keep in mind that revoking this request may limit the effectiveness of treatment and/or disrupt treatment.

Prescription History

By signing this form, you agree to the access/review of your external prescriptions history obtained from local and national pharmacy databases. Use of this information is used internally for your healthcare and will not be released without your consent, unless deemed medically necessary.

Notice of Privacy Practice is available upon request – Initial One.

_____I request a copy of the "Notice of Privacy Practice"

_____I do not request a copy of the "Notice of Privacy Practice" currently.

I understand that if I am the custodial parent or guardian, medical record information will be released only upon my request. You may sign and complete a written "Release of Information" (ROI), which will be maintained on file with Pearl Health Clinic. This release shall indicate who this information shall be disclosed to. Please note that non-custodial parents or guardians with appropriate legal documentation shall have access to these records, regardless of if there is a release on file.

I authorize Pearl Health Clinic to be able to speak with the following people regarding my medical information:

Name: _____ **Relation:** _____ **Name:** _____ **Relation:** _____

Name:_____ **Relation:** _____ **Name:** _____ **Relation:** _____

Printed Name of Parent/Guardian (if under 18 years of age): _____ **Relation:** _____

Signature of Patient or Parent/Guardian of Patient: **Date:**

Effective July 1, 2024, Idaho healthcare providers must obtain parental consent to treat unemancipated minors or face civil liability except in emergency cases. In addition, parents will have the right to access the medical records of their minor children subject to very limited exceptions.

Minor Patient: _____ Birthdate: ____/____/____

1. **Authority.** I am the parent, guardian or other person legally authorized by Idaho law to consent for health care services for the Minor Patient pursuant to Idaho Code § 32-1015.

2. **Consent for Treatment.** I voluntarily consent to and authorize Pearl Health Clinic and its employed or affiliated physicians, practitioners, and staff (collectively "Providers") to render the following health care services to the Minor Patient:

[ ] **General Consent:** Medical evaluation, diagnosis and treatment; diagnostic services including lab tests or radiology procedures; prescription and administration of medications; counseling; and any other health care services as defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider. This consent shall constitute a "blanket consent" within the meaning of I.C. § 32-1015(4)(a) and no further consent is required to authorize such health care services.

or

[ ] **Consent for Specific Care [Describe]:**

_____

_____

3. **Information.** The Provider has explained the nature of the proposed heath care services, alternatives, and their related risks and benefits, or I have waived my right to receive such information. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction or I have declined to ask such questions. If I require additional information concerning the health care services, I will contact Pearl Health Clinic or the Provider to discuss such services. I understand that the practice of medicine is not an exact science and no promises or guarantees have been made nor can they be made to me concerning the outcome of the health care services.

4. **Financial Responsibility.** I agree that I am ultimately responsible for payment for the health care services rendered to the Minor Patient and agree to comply with Pearl Health Clinic Financial Policies. I will promptly pay any co-payments, deductibles, or other amounts not covered by applicable insurance or third-party payor program. I will cooperate with Pearl Health Clinic in obtaining reimbursement for the health care services from any third-party payor, and hereby assign to Pearl Health Clinic the right to submit claims for payment to third-party payers and retain such payments. To the extent allowed by law, I will remain responsible for any amount not paid by any third-party payor for health care services, including but not limited to costs relating to infectious, contagious or communicable diseases within the meaning of I.C. § 39-3801. If the Minor Patient's account becomes delinquent, I agree to pay interest and fees according to Pearl Health Clinic's Financial Policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys' fees, and court costs.

I have read, understand, and agree to the foregoing, and I understand and acknowledge that Pearl Health Clinic and/or its Providers will render health care services in reliance on this consent.

Name: _____ Relationship to Minor Patient: _____

Signature: _____ Date: _____

Idaho Medical Records Release Form

Patient Name: _____ DOB: _____

Previous Name: _____ Daytime Phone: _____

Date Records Needed By: _____

I request and authorize my information to be released to: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I request information from: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

☐Verbal Release (please specify what can be disclosed):

Health Information to be disclosed (check all that apply):

- ☐ Last Medical Provider Note
- ☐ Chart notes including psychotherapy
- ☐ Lab Reports
- ☐ X-ray/Diagnostic Reports
- ☐ Medication List
- ☐ Billing Records
- ☐ Immunizations
- ☐ Appointment info only
- ☐ Psychiatric Testing
- ☐Other: _____

☐All health care information that does not include sensitive information, please see below (includes 2yrs, unless specified)

I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological or mental conditions, drug and or alcohol use or abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing. I consent for the following information to be disclosed: (check any/all that apply):

☐HIV (AIDS virus) ☐ Sexually transmitted disease ☐ Drug and/or alcohol use

☐Psychiatric disorder/mental health (including CDA, Counseling, Therapy, etc.)

Reason for Authorization: ☐ At the request of the individual; ☐ Other: _____

Expiration: ☐ Date: _____ OR ☐ Event (one time release): _____

If date is not specified, this request will expire in 90 days from the date of signature.

If the release is for the patient's **EMPLOYER** or **FINANCIAL INSTITUTION** for reasons other than payment, this authorization will remain valid for only 90 days. Patient may revoke this authorization at any time prior to expiration by notifying in writing.

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health, and sexually transmitted diseases, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. The releasor or releasee may not condition treatment, payment, enrollment, or eligibility on the authorization of this release.

****Signature/Legally Responsible Party:** _____ **Relationship to Patient:** _____ **Date:** _____

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.

We are required by law to maintain the privacy of your health information and to notify you of our legal duties and privacy practices with respect to your protected health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 C.F.R. part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses and Disclosures We May Make Without Written Authorization**. We may use or disclose your protected health information for certain purposes without your written authorization, including the following:

   Treatment. We may use or disclose information for purposes of treating you, e.g., our staff may use your information or disclose your information to another health care provider to diagnose or treat you. In addition, we may use or disclose your information to provide appointment reminders, or to provide information about treatment alternatives or other health-related benefits and services we offer that may be of interest to you.

   Payment. We may use or disclose information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

   Healthcare Operations. We may use or disclose information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to review the performance of our staff or make decisions affecting the practice.

   Other Uses or Disclosures. We may also use or disclose information for certain other purposes allowed by 45 C.F.R. § 164.512 or other applicable laws and regulations, including the following purposes:

   - To avoid a serious threat to your health or safety or the health or safety of others
   - As required by state or federal law, e.g., to report abuse or neglect or certain other occurrences.
   - As allowed by workers compensation laws for use in workers compensation proceedings.
   - For certain public health activities, e.g., to report certain events or diseases.
   - For certain public health oversight activities, e.g., to allow public health agencies to conduct investigations or inspections.
   - In response to a court order, warrant or subpoena in judicial or administrative proceedings.
   - Subject to specific limitations, in response to certain requests by law enforcement, e.g., to help identify or locate a fugitive, witness or victim, or to report a crime.
   - For research purposes if certain conditions are satisfied.

2. **Disclosure to Persons Involved in Your Healthcare.** Unless you tell us otherwise in advance, we may disclose information to a member of your family, relative, friend, or other person who is involved in your healthcare or the payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment. <u>If you object to such disclosures, please notify the Privacy Officer identified below.</u>

3. **Uses and Disclosures with Your Written Authorization.** We will make other uses and disclosures of your information only with your written authorization. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction.
- We normally contact you by telephone or mail at your home address. We will accommodate reasonable requests to contact you by alternative means or at alternative locations.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes to This Notice.** We reserve the right to change the terms of our Notice of Privacy Practices at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist, or the Privacy Officer identified below.

6. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer identified below. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact our Privacy Contact:

Privacy Officer Contact Information

Phone: 208-346-7500

Email: info@pearlhealth.org

Effective Date: This Notice is effective June 1, 2025