



PERSONAL RESPONSE SYSTEM

PO BOX 1176, Seneca SC 29679 • 1-866-672-4852 • Fax 803-996-4357 • www.helpforyou.com

HELP PERSONAL RESPONSE UNIT
Landline Units Payment Authorization Form

Subscriber: _____ Account#: _____

Initial Payment Due During Installation

This will be paid via: Visa MasterCard Discover Check Agency

Item description				Amount
Monitoring Service	<input type="checkbox"/> Monthly \$29.95	<input type="checkbox"/> Quarterly \$89.85	<input type="checkbox"/> Annually \$359.40	
Additional Pendants	<input type="checkbox"/> Monthly \$10.00	<input type="checkbox"/> Quarterly \$30.00	<input type="checkbox"/> Annually \$120.00	
Total Due at Installation:				\$

Method of Payment for Subsequent Billing

Payment Method (select one)		Payment Plan (Select One)
<input type="checkbox"/>	Automatically Debit/Credit Card (card information listed below) Sign # 1	<input type="checkbox"/> \$ 29.95 Per Month
<input type="checkbox"/>	Withdrawal from checking account (complete ACH Debit From) Sign #2	<input type="checkbox"/> \$ 89.85 Every 3 Months*
<input type="checkbox"/>	Customer will remit payment after receiving an invoice. Sign # 2	<input type="checkbox"/> \$ 179.70 Every 6 Months*
Upon cancellation of service, any unused prepaid months of service will be refunded minus any discounts.		<input type="checkbox"/> \$ 359.40 Yearly

1. I hereby authorize Help Services, Inc. to charge my credit card as listed above or draft the above listed charges from my checking account as listed on the ACH Debit Form below.

Responsible Payer Signature: _____ **Date:** ___/___/___

2. The information above is for file purposes only and will be charged for initial payment and should not be charged for services thereafter, all future payments will be remitted upon receipt of an invoice.

(ONLY SIGN HERE INFORMATION ABOVE IS FOR FILING PURPOSES AND NOT TO BE CHARGED)

Responsible Payer Signature: _____ **Date:** ___/___/___

Initials: _____



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SIGN FOR AUTHORIZATION OF AUTO PAY

I authorize Help Services, Inc. to verify the information given on this application and to process payment now and in the future. I will provide Help Services, Inc. with a cancellation date should I choose to cancel this set up. This payment is for service of my PERS (medical alarming system) with Help Services, Inc.

PLEASE COMPLETE EITHER THE CHECK DRAFT INFORMATION OR THE CREDIT/DEBIT CARD INFORMATION.

PRINT NAME OF SUBSCRIBER

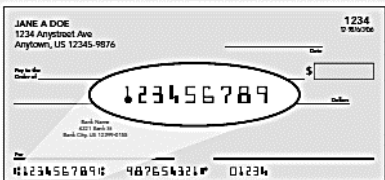
ACCOUNT NUMBER

PRINT NAME OF PERSON RESPONSIBLE FOR PAYMENT

SIGNATURE

DATE

ACH (Automatic Bank Draft, or Check by Phone)

BANK ACCOUNT INFORMATION	Bank name		Telephone		
	Street Address		City	State	Zip
	Name on bank account		Tip: Your account routing number is the 9-digit number located in the lower left corner of your personal checks. 		
	Bank account number				
Account routing number (see tip at right)					

I AUTHORIZE HELP SERVICES, INC. AND THE BANK NAMED ABOVE TO INITIATE MONTHLY WITHDRAWALS FROM MY CHECKING ACCOUNT, AS INDICATED.

SIGNATURE OF BANK ACCOUNT HOLDER

MONTHLY PAYMENT AMT.

DATE

The ACH fund transfer will remain in effect until you notify Help Services, Inc. to cancel. If you wish to stop the ACH fund transfer, you must notify Help Services, Inc. seven business days prior to the month premium is due. If the necessary funds are not present in the account the designated day for automatic payment, Help Services, Inc. will send an invoice for the past due premium. This premium must be paid in order to avoid interruptions of service.

Credit/Debit Card Account Information- Please complete all fields.

CREDIT CARD NUMBER

EXPIRATION DATE (MM /YY)

NAME ON CREDIT CARD

NAME OF PERSON RESPONSIBLE FOR PAYMENT

BILLING CITY STATE/ZIP

Authorization

Help Services, Inc. is hereby authorized to charge the indicated credit card or ACH on a recurring basis for payment of services performed on my behalf. I agree that if I have any problems or questions regarding my service that I will contact Help Services, Inc. for assistance, and I agree that I will not dispute any charges unless I have already attempted to rectify the situation directly with Help Service, Inc. I agree to inform Help Services, Inc. of any change (including expiration date) in my credit card information, which may be required in writing. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this recurring billing agreement. I agree that termination of this recurring credit card authorization must be in writing to Help Services, Inc.

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Location Number:

Subscriber Acct Number:

Unit ID:

Serial Number:

Pendant Serial Number:

1. Subscriber Information

LAST NAME FIRST NAME MI

ORDER DATE INSTALL DATE UNIT TYPE

HOME PHONE CELL OR OTHER PHONE

ADDRESS

CITY STATE ZIP CODE

COUNTY SUBSCRIBER TYPE

HIDDEN KEY INFORMATION/LOCK BOX CODE

2. Subscriber Health Data

ALLERGIES

DISABILITIES

BIRTH DATE SEX

3. Emergency Information

LOCAL EMS HOSPITAL PREFERENCE

PHYSICIAN'S NAME PHYSICIAN'S PHONE

SPECIAL DIRECTIONS

4. Next of Kin Information

LAST NAME FIRST NAME RELATIONSHIP

ADDRESS

CITY STATE ZIP CODE

HOME PHONE CELL OR OTHER PHONE

5. Billing Information

LAST NAME FIRST NAME

ADDRESS CITY STATE ZIP CODE

HOME PHONE CELL OR OTHER PHONE

6. Responder Information

Responder No. 1

LAST NAME FIRST NAME RELATIONSHIP/KEY?

ADDRESS CITY STATE ZIP CODE

HOME PHONE CELL OR OTHER PHONE

Responder No. 2

LAST NAME FIRST NAME RELATIONSHIP/KEY?

ADDRESS CITY STATE ZIP CODE

HOME PHONE CELL OR OTHER PHONE

Responder No. 3

LAST NAME FIRST NAME RELATIONSHIP/KEY?

ADDRESS CITY STATE ZIP CODE

HOME PHONE CELL OR OTHER PHONE

Initials: _____



HELP® RESPONSE CENTER AGREEMENT TERMS AND CONDITIONS

That for the consideration and covenants hereinafter specified, the parties hereto, their heirs, successors and assigns do mutually agree to the following:

1. It is agreed between the parties that Help®, hereinafter referred to as the “Company,” will furnish to you, hereinafter referred to as the “Subscriber,” a Help® personal response system, hereinafter referred to as the “System,” to be monitored by an independent call center, hereinafter referred to as the “Call Center,” subject to the terms and conditions set forth below. The Call Center is not owned or operated by the Company. The Subscriber agrees that the Company does not assume and shall not be liable for any representations, acts, or omissions of the Call Center. The initial term of this agreement is one month, and will automatically continue from month to month thereafter unless either party gives prior written notice to the other of the intention to terminate service, which shall end on the last day of the month following the month in which notice of termination was received.

MONITORING SERVICE WILL NOT BEGIN UNTIL WE HAVE RECEIVED AND APPROVED: (A) A FULLY EXECUTED COPY OF THIS AGREEMENT, (B) COMPLETED EMERGENCY AND RESPONSE INFORMATION, AND (C) VALID TEST SIGNALS FROM THE SYSTEM.

2. **MEDICAL RESPONSE:** Upon receipt of a medical response signal, the Call Center will attempt to use the two-way voice feature of the System if so equipped, and/or call the Subscriber’s premises, in an effort to contact someone at the Subscriber’s home and to determine if an emergency condition exists. If the Subscriber’s system does not have two-way voice capabilities, the Call Center will try to contact the Subscriber by phone. If the Call Center is unable to contact someone in the home, or it is reasonably determined that an emergency condition exists, the Call Center will make every reasonable effort to notify an available responder set forth on the Subscriber’s responder list, or the appropriate emergency services in the order specified in the Subscriber’s response list. The Subscriber understands and authorizes the Company and/or the Call Center to release and disclose the following information to any and all responders designated by the Subscriber: (a) the name of the Subscriber, (b) the location from which the Subscriber’s alarm was received, (c) and any other such information as may be requested by the 911 center, public safety answering point, or communication center. Following any notification to the 911 center, public safety answering point, or communications center, the Company or the Call Center provider shall attempt to notify the responders on the Subscriber’s calling list in accordance with the voice-to-voice request of the Subscriber or, if no instructions are received from the Subscriber, to the responders specified on the calling list in the order specified in this agreement.
 - 2.1. **INACTIVITY MONITORING:** If the Subscriber selects this optional feature, the Subscriber will select check-in times in accordance with the User’s Manual. Upon receipt of a non-activity signal, the Call Center will attempt to use the two-way voice feature of the system, if so equipped, and/or call the Subscriber’s premises, in order to contact someone at the Subscriber’s home and determine if an emergency condition exists. If the Call Center is unable to contact someone in the home, or if it is reasonably determined that an emergency condition exists, the Call Center will make every reasonable effort to notify the first available responder set forth on the Subscriber’s responder list and emergency services.
 - 2.2. **SMOKE DETECTOR MONITORING:** Upon receipt of a smoke detector alarm signal, the Call Center will attempt to use the two-way voice feature of the system, if so equipped, and/or call the Subscriber’s premises, in order to contact someone at the Subscriber’s home and determine if an emergency condition exists. If the Call Center is unable to contact someone in the Subscriber’s home, or if it is reasonably determined that an emergency condition exists, the Call Center will make every reasonable effort to notify emergency services set forth on the Subscriber’s responder list.
 - 2.3. **FALSE SIGNALS:** To avoid false signals, the Call Center may use the two-way voice feature of the System and/or call the Subscriber’s premises first to determine if an actual emergency exists before

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notifying anyone of the signal. If the Call Center has reason to believe that no actual emergency exists, it may choose not to place calls to the Subscriber's responders, including public emergency response agencies. The Company may discontinue any particular response service; a written notice will be given to you if required by any government agency or our liability insurance provider. Neither the Company, nor the Call Center, are not responsible for the nature or promptness of the response taken by any responder. In the event that an emergency signal is received, and if responders or emergency authorities are sent, the Subscriber acknowledges, and accepts, that forced entry may be used if necessary to respond appropriately to the emergency. The Subscriber shall indemnify, hold harmless, and defend any such responder, emergency authority, the Company or its agent or employer against all claims, suits, damages, or costs resulting from such forced entry. The Subscriber, the Subscriber's family members, and any others who use the system, agree to use the system carefully in order to avoid causing false signals. If the Call Center receives an excessive number of false signals, determined by the Company's sole discretion, the Company may cancel the monitoring service. If a false signal fine or penalty is charged to the Company by any government agency, the Subscriber agrees to reimburse the Company for any such fees.

3. **MEDICAL OR RELATED EXPENSES:** In the event the Subscriber utilizes the System by sending the Call Center a signal, the Subscriber does hereby authorize the Company and/or the Call Center to seek, to notify, or obtain assistance. The Subscriber shall be responsible for, and agrees to pay, any cost whatsoever incurred as a result of the Subscriber's use of the System.
4. **ADDITIONAL SERVICES AND EQUIPMENT:** The System includes a communications device that sends signals to the Call Center and provides two-way voice communications over the Subscriber's regular telephone service. The subscriber will pay for all telephone charges, including, if necessary, the installation fee for a special jack to connect the System to a telephone service. The Company recommends that the system be connected to the telephone service on a special telephone jack (RJ31X or equivalent), which will give the system priority over other telephone equipment in the Subscriber's home. However, when the system is activated, the Subscriber will not be able to use the telephones in their home to make other calls (such as calls to the 911 emergency operator); therefore, the Subscriber may choose to have the system placed on a separate line at the Subscriber's expense. If the Subscriber's telephone service is out of order, placed on vacation status, or otherwise not working, a signal will not be transmittable and the two-way voice feature will not work; unless notified, the Company, nor the Call Center, will know of the telephone service problem. The Subscriber also agrees to supply, at their own expense, the continuous power supply (24-hour 110 volt AC current) that is required to power the system.
5. **THE SUBSCRIBER'S DUTIES:** The Subscriber agrees and understands that he/she has a continuing duty to: (a) pay the applicable monthly monitoring fees, (b) instruct family members and others who may use the system on its proper use, (c) test the system and send test signals monthly to the Call Center in accordance with the Company's instructions, (d) obtain and keep in effect all permits or licenses that may be required for the use of the System, and (e) notify the Company in writing of any changes in the public emergency response agencies and responders on the Subscriber's emergency contact list. The personal transmitter is battery operated. When the battery becomes low, the personal transmitter must be replaced. If the system activates a low battery signal, the Call Center will contact the Subscriber, or appointed representative, detailing how to obtain a new personal transmitter and any cost associated with the replacement. If a problem in the system occurs, the Subscriber should notify the Call Center and the Company immediately.
6. **TERMINATION OF AGREEMENT, SUSPENSION, AND/OR DISCONNECTION:** The Subscriber understands that the Company may stop or suspend the Call Center service if; (a) lightning strikes, severe weather, earthquakes, or other such events beyond the Company's control affect the operation of the Call Center or so severely damage the Subscriber's premises that continuing service would be impractical; (b) there is an interruption or unavailability of the telephone service between the System and the Call Center; (c) the Company is unable to provide service because of some action or ruling by any government authority. The Company may terminate Call Center services by giving the Subscriber ten (10) days prior written notice. Termination may occur in the event that (i) the Call Center notifies the Company of its decision to terminate service for the subscriber for any reason, (ii) the Subscriber fails or refuses to make payment for

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services furnished or to be furnished to the Subscriber by the Company, or (iii) the System is not maintained in good operating condition and repair. Upon giving such notice, this agreement and all of the Company's responsibilities hereunder shall come to an end and the Company shall be considered released from all claims the Subscriber may have against the Company or the Call Center. Upon termination of this Agreement for any reason, the Subscriber agrees to pay the Company all amounts accrued and unpaid through termination and hereby authorizes the Company to remotely disconnect the System from the Call Center and discontinue monitoring. The Subscriber will return the System to the Company or the Call Center. Should the Subscriber fail to return the System within 20 (twenty) days after termination of service for any reason, the Subscriber hereby authorizes the Company, or its affiliate, to debit the credit card the Subscriber has on file for \$399.00.

- 7. **ASSIGNMENTS:** The Company reserves the right to transfer or assign this agreement to any Call Center with or without the consent of the Subscriber. The Subscriber may transfer this agreement to a third party, including someone who purchases or rents the Subscriber's home, if such third party agrees to, and signs, the Company's then current form of HELP Personal Response System Agreement.
- 8. **LIMITATION OF LIABILITY:** The Subscriber agrees and understands that the company is not an insurer and that insurance covering personal injury including death and real or personal property loss or damage in, about, or to the premises shall be obtained by the Subscriber. The Subscriber agrees and understands that the Company makes no guarantee, representation, or warranty, including without limitation, any implied warranty of merchantability or fitness for a particular purpose that the equipment and services are designed to reduce, but not eliminate, certain risks of loss and that the amounts being charged by the company are not sufficient to warrant or guarantee that either no loss or damage will occur or increased loss or damage will not occur. The Subscriber agrees and understands that the Company is not liable for any loss or damage which may occur prior to, contemporaneous with, or subsequent to, the execution of this agreement, even if due to the active or passive sole, joint, or several negligence of the company or its agents, servants, employees, suppliers, or subcontractors, or to the improper performance of and/or failure to perform of the equipment, or breach of contract, express or implied or breach of warranty, express or implied, or by loss or damage to facilities necessary to operate the system. The Subscriber agrees and understands that should there arise any liability on the part of the company for personal injury and/or property damage, real or personal, which is connected with, arises out of, or from, or results from the remote programming or monitoring of any equipment or system, and/or the dispatch of individuals to the premises, and/or the failure or faulty operation of the system or the call center facilities, and/or the active or passive sole, joint, or several negligence (including gross negligence) of the company and/or its agents, servants, employees, suppliers or subcontractors including, without limitation, acts, errors or omissions which occur prior to, contemporaneously with or subsequent to the execution of this agreement, and/or any claim(s) brought in product or strict liability and/or breach of warranty, express, or implied, and/or breach of contract, expressed or implied, and/or any claim for distribution or indemnification, whether in contract or in tort or equity, including without limitation, any general, direct, special, incidental, including without limitation, any general, direct, special, incidental, exemplary, punitive and/or consequential damages irrespective of cause, such liability shall be limited to the maximum sum of \$500.00, and this liability shall be the exclusive remedy. In the event the Subscriber wishes to increase this maximum amount of such limited liability, the Subscriber may, as a matter of right, obtain from the company a higher limit by paying an additional amount for the increase in such limit of liability, but the Subscriber understands such higher amounts of limited liability in no way will be interpreted to hold the company as an insurer.
- 8.1. **THIRD PARTY INDEMNIFICATION AND SUBROGATION:** If anyone other than the Subscriber asks the Company or the Call Center to pay for any harm or damages (including personal injury, death, or property loss) connected with or resulting from (i) a failure of the personal response system or services, (ii) negligence or any other improper or careless activity in providing the System or services or (iii) a claim for indemnification or contribution, the Subscriber will pay to the Company or the Call Center (a) any amount which a court orders the Company or the Call Center to pay or which the Company or the Call Center may reasonably agree to pay, and (b) the amount of the Company's or the Call Center's reasonable attorney's fees and any other loss or costs that the Company or the Call Center

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may pay in connection with the harm or damages. Unless prohibited by the Subscriber's homeowners or other property insurance policy, the Subscriber agrees to release the Company and/or the Call Center from any claims of any parties suing through the Subscriber's authority or in the Subscriber's name, such as the Subscriber's insurance company, and the Subscriber agrees to defend the Company against any such claim.

- 9. LIMITATION ON LAWSUITS, WAIVER OF JURY TRIAL: Both the Company and the Subscriber agree that no lawsuit, or any other legal proceeding connected with this agreement, shall be brought or filed more than one year after the incident giving rise to the claim occurred. IN ADDITION, ANY SUCH LEGAL PROCEEDING SHALL NOT BE HEARD BEFORE A JURY. EACH PARTY GIVES UP ANY RIGHT TO A JURY TRIAL.
10. ENTIRE AGREEMENT: The entire and only agreement between the Company and the Subscriber is written in this Agreement. It replaces any earlier oral or written understandings or agreements. It may only be changed by written agreement signed by the Company and the Subscriber. THIS AGREEMENT CANNOT BE AMENDED, ALTERED, OR MODIFIED BY ANY AGREEMENT ENTERED INTO BETWEEN THE CALL CENTER AND THE SUBSCRIBER. OUR DUTY AND OBLIGATION TO PROVIDE MONITORING SERVICE TO THE SUBSCRIBER ARISE SOLELY FROM THIS AGREEMENT.
11. NO THIRD PARTY BENEFICIARY: You are not a third party beneficiary to any agreement between the Company and the Call Center.
12. SEVERABILITY: If any provision of this agreement is found to be invalid or illegal by a court, the balance of the agreement shall remain in force and the invalidated provision shall be extended only to the minimum limit applicable under the laws of the state the court is sitting with competent jurisdiction.
13. GOVERNING LAW: The Subscriber agrees that this agreement is performed in the state of South Carolina. The Subscriber and the Company acknowledge that a substantial portion of the performance and execution of this agreement occurred, or shall occur, in Oconee County, South Carolina, and that the Subscriber and the Company (a) agree that any suit, action, or legal proceeding arising out of or relating to this agreement shall be brought in the courts of record of the State of South Carolina in Oconee County or the District Court of the United States, District of South Carolina; (b) consent to the jurisdiction of each such court in any suit, action, or proceeding; and (c) waive any objection to the laying of venue of any such suit, action or proceeding in any of such courts.
14. KENTUCKY RESIDENTS: All Subscribers residing in the state of Kentucky may designate in this agreement that, in response to receiving the Subscriber's alarm, the first and primary contact for the dispatch of aid shall be from the personal emergency response system provider to a 911 center, public safety answering point, or communications center in the jurisdiction from which the alarm was received; the Subscriber may designate in this agreement that if, in response to receiving the Subscriber's alarm, the personal emergency response system provider is not able to solicit a verbal response from the Subscriber, then the personal emergency response system provider shall call the Subscriber's 911 center, public safety answering point, or communications center before contacting the Subscriber's designated responders. If the Subscriber does not designate in this agreement a 911 center, public safety answering point, or communications center as the primary responder, then the Subscriber's 911 center, public safety answering point, or communications center shall become the default secondary responder after the personal emergency response system provider has attempted, without success, to notify all other responders designated by the Subscriber.
14.1 KENTUCKY RESIDENT DISCLOSURE STATEMENT: The Subscriber has the option to designate in this agreement a 911 center, public safety answering point, or communications center as the primary responder. I acknowledge this statement by initialing below.
15. PRIVACY AND MEDICAL INFORMATION: the Subscriber has been given a copy of the Help Services, Inc. Notice of Privacy Practices and understands their rights.

Signature of the Subscriber: _____

Print Name: _____

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HELP SERVICES, INC. AND SUBSIDIARIES 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.

USE AND DISCLOSURE OF HEALTH INFORMATION

Consistent with applicable Federal and State regulations, Help Services, Inc. and Subsidiaries (hereinafter referred to as "Agency") may use your health information for the purposes of providing you treatment, obtaining payment for your care, and conducting health care operations. In some circumstances, your health information may be used or disclosed for these purposes without your written consent.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES THAT MAY REQUIRE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN CONSENT:

To Provide Treatment: The Agency may use your health information to coordinate care - both pre-Admission and post-Admission -with other health care practitioners and providers involved in your care or treatment. For example, physicians involved in your care will need information about your condition in order to prescribe appropriate treatment or medications. Pharmacists or suppliers of medical equipment will need certain health information to provide ordered services to you.

To Obtain Payment: The Agency may include your health information to bill and collect payment from Medicare, other health insurance plans or third parties for the care you receive from the Agency. For example, the Agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. The Agency may also need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you. Medicare requires diagnosis and treatment information to justify the medical necessity for reimbursement to the Agency.

To Conduct Health Care Operations: The Agency may use and disclose health information for its own operations in order to facilitate the function of the Agency and as necessary, to provide quality care to all of the Agency's patients. Health care operations include such activities as:

- Quality assessment and improvement activities
- Protocol development, case management and care coordination
- Professional review and performance evaluation
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision
- Training of non-health care professionals
- Accreditation, certification, licensing, or credentialing activities
- Review and auditing, including compliance reviews, medical reviews, legal services, and compliance programs
- Business planning and development including cost management, planning related analyses, and formulary development
- Business management and general administrative activities of the Agency

For example, the Agency may use your health information to train its staff, to evaluate staff performance, or to improve health care outcomes and lower costs through comparative analysis of patient data.

For Appointment Reminders: The Agency may use and disclose your health information to contact you as a reminder that you have an appointment for a home visit.

When Legally Required: The Agency will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health: The Agency may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death, and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs, and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.

To Report Abuse, Neglect Or Domestic Violence

To Conduct Health Oversight Activities: The Agency may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Agency, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to the investigation.

In Connection With Judicial And Administrative Proceedings: The Agency may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Agency makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes: As permitted or required by State law, the Agency may disclose your health information to a law enforcement official for certain law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain limited circumstances, when you are the victim of a crime
- To a law enforcement official if the Agency has a suspicion that your death was the result of criminal conduct including criminal conduct at the Agency
- In an emergency in order to report a crime

To Coroners And Medical Examiners: The Agency may disclose your health information to coroners and medical examiners for purposes of determining your cause of death, or for other duties, as authorized by law.

To Funeral Directors: The agency may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, the Agency may disclose your health information prior to, and in reasonable anticipation of your death.

For Organ, Eye Or Tissue Donation: The Agency may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

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For Research Purposes: The Agency may, under very select circumstances, use your health information for research. Before the Agency discloses any of your health information for such research purposes, the Agency will obtain written permission from you or your legal representative or the health information will be abstracted in such a way as to protect your identity.

In The Event of A Serious Threat To Health Or Safety: The Agency may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Agency, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Worker's Compensation: The Agency may disclose protected health information as authorized by, and to the extent necessary to comply with, laws relating to Workers' Compensation or other similar programs established by law that provide benefits for worker-related injuries or illnesses without regard to fault.

For Specified Government Functions: In certain circumstances, the Federal regulations authorize the Agency to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than what is stated above, the Agency will not disclose your health information other than with your written authorization. If you, or your representative, authorizes the Agency to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Agency maintains:

- **Right to request restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or operations. For example, you may request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care. The Agency is not required to agree to your request. Your request must be made in writing. Contact your Agency's Privacy Officer for assistance in submitting a request. *
- **Right to receive confidential communications:** You have the right to request that the Agency communicate with you about medical matters in a certain way or at a certain location. You are not required to provide a reason for your request. The Agency will honor all reasonable requests. Your request must be made in writing. Contact your Agency's Privacy Officer for assistance in submitting a request. *
- **Right to inspect and copy your health information:** You have the right to inspect and copy your health information, including billing records. Your request must be made in writing. Contact your Agency's Privacy Officer for assistance in submitting a request. *
- **Right to amend health care information:** You have the right to request that the Agency amend your records, if you believe that your health information we have about you is incorrect or incomplete. You will be required to provide your reason for the request. Your request must be made in writing. Contact your Agency's Privacy Officer for assistance in submitting a request. *
- **Right to an accounting:** You have the right to request an accounting of disclosures of your health information made by the Agency on or after April 14, 2003 for any reason other than for treatment, payment or health operations. Your request must be made in writing. Contact your Agency's Privacy Officer for assistance in submitting a request. *
- **Right to a paper copy of this notice:** You have a right to a separate paper copy of this Notice at any time even if you have received this Notice previously. Verbal requests will be honored. To obtain a separate paper copy, contact your Agency's Privacy Officer*

You can also obtain a copy of the Agency's Notice of Privacy Practices at its website, www.helpforyou.com

*Agency's Privacy Officer can be reached as follows: (866) 672-4852.

*The Agency will assist you in preparing and submitting accurate and complete written requests. Forward written requests to: Help Services, Inc., Attn: Privacy Officer, PO Box 1176, Seneca SC 29679. All requests will be reviewed on an individual basis in accordance with HIPAA Regulations. The Agency will notify patients of their decision to grant or deny their request and, if applicable, further rights the patient may wish to exercise.

DUTIES OF THE AGENCY

The Agency is required by law to maintain the privacy of your health information and to provide you and your authorized representative this Notice of its duties and privacy practices. The Agency is required to abide by the terms of this Notice as may be amended from time to time. The Agency reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Agency changes this Notice, the Agency will provide a copy of the revised Notice to you or your authorized representative. You or your authorized representative have the right to express complaints to the Agency and to the Secretary of DHHS if you believe that your privacy rights have been violated. Any complaints to the Agency should be made in writing to Help Services, Inc., Attn: Privacy Officer, PO Box 1176, Seneca SC 29679. The Agency encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON:

The Agency has designated a HIPAA Privacy Officer as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, please contact Help Services, Inc., Attn: Privacy Officer, PO Box 1176, Seneca SC 29679 (866) 672-4852.

DATE: This Notice is effective January 1, 2016.

Date: _____

Initials: _____