

**SERVICES AGREEMENT BETWEEN  
COLLIN COUNTY HEALTH CARE FOUNDATION  
AND PRIMACARE MEDICAL CENTERS**

This Agreement, made January 1, 2010 by and between the Collin County Health Care Foundation, 825 N. McDonald Street, McKinney, Texas 75069 and PrimaMed Physicians Association d/b/a PrimaCare Medical Centers, (hereinafter PrimaCare and/or Provider) 11910 Greenville Avenue, Suite 500, Dallas, Texas 75243.

**Whereas**, Collin County Health Care Foundation, hereinafter referred to as "CCHCF", wishes to provide assistance to the most vulnerable, low income United State citizens and legal residents of Collin County, Texas, needing primary and preventive health care; and

**Whereas**, PrimaCare Medical Centers, hereinafter referred to as "Provider", provides low cost primary and preventive health care to persons residing in the Collin County area; and

**Whereas**, PrimaCare Medical Centers has agreed to be a provider of primary care services for CCHCF. A detailed list of services and locations are attached and incorporated herein for all purposes.

**NOW THEREFORE**, this agreement is made and entered into by the Collin County Health Care Foundation and PrimaCare.

1. **Term of Agreement.** This agreement shall be effective as of January 1, 2010 and ends on December 31, 2010.
2. **Scope of Work.** Provider shall perform the following during the term of this agreement:
  - a. CCHCF shall pay Provider to provide limited primary health care to U.S. citizens and legal residents of Collin County, Texas. This agreement will not pay for well visits, or for individuals who are enrolled in SCHIP, Medicaid, Medicare or who have private insurance.
  - b. Provider is required to use due diligence in determining patient eligibility as condition of payment from CCHCF. Patients eligible for payment under this Agreement are those individuals who meet Collin County's eligibility criteria:
    1. Maintain a current and permanent residence within Collin County, Texas; and
    2. Are U.S. Citizens and legal residents of the United States; and
    3. Complete and sign the Collin County Health Care Eligibility Form and HIPAA release; and

4. Who do not have any health insurance, including, but not limited to Medicare, Medicaid, SCHIP, or a private insurance; and
    5. Have an income that is at or below 100% of the Federal Poverty Level; and
    6. Patient must pay PrimaCare a \$20.00 Co-pay for each visit.
  - c. Provider will be paid on a fee-for- service basis of \$110.00 per patient visit.
  - d. Payment from CCHCF to Provider shall be contingent upon the completion of a signed Collin County Health Care Eligibility Form and HIPAA release sent to CCHCF as a bill. CCHCF reserves the right to reject any claim for payment for incomplete or unverifiable data submitted by Provider.
  - e. PrimaCare will submit claims to CCHCF once per week.
  - f. CCHCF will only pay for patient visits between January 1, 2010 and December 31, 2010, subject to a maximum payout of \$400,000.00.
  - g. A prearranged site visit may be conducted on behalf of the CCHCF by the Manager, Collin County Health Care Services, her designee or the Collin County Auditors Office. CCHCF reserves the right to audit records for financial accuracy and contractual compliance for any and all claims made for payment for services rendered under this contract.
  - h. Any revision to this scope of work, including the use of funds, must be mutually approved in writing prior to the implementation of the revision, by both the Manager of the Collin County Health Care Services and Provider.
3. **Payment of Services.** The maximum available to all service providers for Collin County 2010 Fiscal Year is \$400,000. The payment will be on an after-the fact, fee-for-services-basis. No more than \$110.00 will be paid for each patient visit. Once the \$400,000.00 is expended, CCHCF will not reimburse contracted vendors for any more visits or services provided during the 2010 calendar year. CCHCF will timely pay PrimaCare Medical Center after review and approval of any claim submitted.
4. The Collin County Health Care Foundation reserves the right to adjust the payments based on incomplete or unverifiable data. Invoices shall be submitted to Lena Decker at [LDecker@co.collin.tx.us](mailto:LDecker@co.collin.tx.us).
5. **Indemnification.** To the extent allowed by law, each party agrees to release, defend, indemnify, and hold harmless the other (and its officers, agents, and employees) from and against all claims or causes of action for injuries (including death), property damages (including loss of use), and any other losses, demands, suits, judgments and costs, including reasonable attorneys' fees and expenses, in any way arising out of, related to, or resulting from performance under this agreement, or caused by its negligent acts or omissions (or those of its respective officers, agents, employees, or any other third parties for whom it is legally responsible) in connection with performing this agreement. Provider expressly agrees to indemnify and defend CCHCF for any medical malpractice

claim, or related claim, brought against Provider in which CCHCF is made a party.

6. **Provider Licensure and Insurance.** Provider warrants that it is in legal compliance with all State and Federal Medical licensure requirements. Provider is licensed to provide Medical care. Provider agrees to notify CCHCF of any suspension, revocation, or disciplinary action by any State or Federal Licensing body related to Provider's ability to provide health care. Provider has a current malpractice insurance policy which covers the services contemplated by this agreement.
7. **Venue.** The laws of the State of Texas shall govern the interpretation, validity, performance and enforcement of this agreement. The parties agree that this agreement is performable in Collin County, Texas and that exclusive venue shall lie in Collin County, Texas.
8. **Confidentiality of Protected Health Information.** Provider is required to comply with state and federal laws relating to the privacy and confidentiality of patient and client records that contain protected health information, or other health information made confidential by law.

Provider agrees that CCHCF is authorized to request, collect and receive protected health information under this agreement. Provider agrees to have each client or legal guardian of the client treated under this agreement to sign the attached HIPAA release form as part of the Collin County Health Care Eligibility Form. This data may be used by CCHCF, but is not limited to, verify contractual compliance, statistical research, health research and awareness.

As further condition for transmitting the data and information subject to this agreement, Provider agrees to execute the attached Business Associate Agreement. Attached as part of this Agreement.

9. **Successors and Assigns.** This agreement shall be binding upon parties hereto, their successor, heirs, personal representatives and assigns. Neither party will assign or transfer an interest in this agreement without the written consent of the other party.
10. **Severability.** The provisions of this agreement are severable. If any paragraph, section, subdivision, sentence, clause, or phrase of this agreement is for any reason held by court of competent jurisdiction to be contrary to law or contrary to any rule or regulation having the force and effect of the law, the remaining portions of the agreement shall be enforced as if the invalid provisions have never been included.
11. **Entire Agreement.** This agreement embodies the entire agreement between the parties and may only be modified in writing executed by both parties.

12. **Immunity.** It is expressly understood and agreed that, in the execution of this agreement, neither party waives, nor shall be deemed hereby to have waived any immunity or defense that would otherwise be available to it against claims arising in the exercise of governmental powers and functions. By entering into this agreement, the parties do not create any obligations, express or implied, other than those set forth herein, and this agreement shall not create any rights in parties not signatories hereto.
13. **Termination.** This agreement may be terminated by either party for any reason after thirty (30) days written notice. The written notice shall be sent to the addresses identified in the first paragraph of this Agreement. Provider shall be paid for all services provided up to the effective date of termination upon proper proof and submission of all required documentation.

PrimaCare Medical Center

By: Jennifer Stephenson  
Name: Jennifer Stephenson  
Title: Executive Director  
Date: 10-8-09

Collin County Health Care Foundation

By: Keith Self  
Name: Keith Self  
Title: President  
Date: 11/11/09

11-9-09 11:00 AM  
11-9-09 11:00 AM



Date: \_\_\_\_\_ Time: \_\_\_\_\_ New / Ret \_\_\_\_\_ Acct #: \_\_\_\_\_  
 Name (Last, First, MI): \_\_\_\_\_ SS#: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F \_\_\_\_\_ Home#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Resp Party/Employer:		Work#:		CPT		Orthopedic Supplies		Fee	DX	CPT	X-Rays	Fee	DX
99199	Medical Records Duplication			99070, IP	Ice Pack					74000	Abdomen 1 vw		
99199	Xray Duplication			A4565	Sling (3129)					74020	Abdomen 2 vw		
				A4570, GG	Splint, Finger (All) (1900-1906, 1944)					73610	Ankle 3 vw		
CPT	Injections/Medications	Fee	DX	Q4022	Splint/Cast-Short Arm-FBRGLS (11+ YR)					72040	Cervical Spine, AP&Lat, Odontoid		
J0170	Adrenalin/Epinephrine 1:1000			Q4024	Splint/Cast-Short Arm-FBRGLS (0-10 YR)					72050	Cervical Spine Complete		
J7612	Albuterol / Ventolin			Q4038	Splint Short Leg-FBRGLS (11+ YR)					71010	Chest PA		
J0690	Ancef 500 mg (Cefazolin)			Q4040	Splint Short Leg-FBRGLS (0-10 YR)					71020	Chest PA & LAT		
-ANCEF1	Ancef 1 gm (Cefazolin)									73080	Elbow 3 vw		
J1200	Benadryl 50 mg									73140	Finger(s) 3 vw		
J0698	Claforan 1 gm									73630	Foot 3 vw		
J1030	Depo-Medrol 40 mg/cc									73090	Forearm AP&Lat		
J1040	Depo-Medrol 80 mg/cc									73130	Hand		
-DEPO120	Depo-Medrol 120 mg/cc									73510	Hip w/ AP Pelvis		
-J1100	Dexamethasone Sodium Phos., 4mg									73562	Knee, complete 3 vw		
J3301	Kenalog 40 mg/cc									72100	Lumbar Spine 3 vw, AP&Lat, L5-S1		
J2010	Linocin up to 300 mg									72110	Lumbar Spine, complete		
J2300	Nubain 10 mg									71101	Ribs 3 vw		
J2550	Phenergan up to 50 mg									73030	Shoulder 2 vw		
J0696	Rocephin 250 mg			CPT	Miscellaneous	Fee	DX			70220	Sinuses 3 vw		
-ROCEP500	Rocephin 500 mg			A4550	Procedure Tray					72070	Thoracic Spine, AP&Lat		
-ROCEP1	Rocephin 1 gm			92552	Audiometry, Pure Tone					73580	Tibia/Fibula, AP&Lat		
J2920	Solu-Medrol 40 mg/cc			92567	Tympanometry					73660	Toes(s) 3 vw		
J2930	Solu-Medrol 125 mg/cc			93000	EKG w/Interpretation (12 lead)					73110	Wrist 3 vw		
J0595	Stadol 1-2 mg			90760	IV Fluid Hydration, initial up to 1 hr.								
-TOR60	Toradol 60 mg			90761	IV Fluid Hydration, ea add hr, up to 8 hrs								
				90765	IV Fluid Therapy, initial up to 1 hr.								
				90766	IV Fluid Therapy, ea add hr, up to 8 hrs					CPT	Laboratory	Fee	DX
90772	Injection Admin Fee			94640	Nebulizer-includes tubing;no Meds					36415	Venipuncture		
				-O2MASK	Oxygen Treatment (Mask)					36416	Fingerstick		
				-O2CANN	Oxygen Treatment (Canula)					99000	Specimen Handling Fee		
CPT	Immunizations	Fee	DX	A4614	Peak Flow Meter					82055	Alcohol, Ethyl any specimen except breath		
90732	Pneumovax			94760	Pulse oximeter					80048	Basic Metabolic panel		
90658	Flu Shot			94060	Spirometry: Bronchospasm Evaluation, Pre & Post					82075	Breath Alcohol, BAT		
86580	TB- Mantoux Intradermal			94010	Spirometry w/interperation					85025	CBC w/ partial diff		
90714	Td (7+)			94375	Spirometry: Respiratory Flow Volume Loop					87490	Chlamydia DNA Probe		
				94664	Demonstration / Evaluation of Utilization of Device					-CHLJGC	Chlamydia / GC, urine		
90471	Immunization Admin Fee			CPT	Other Procedures	Fee	DX			80053	Comp. Metabolic panel		
				69210	Removal, Ear Wax					FLU	Flu test		
				11100	Bx of skin lesion single w/simple closure					87590	GC DNA Probe		
				11101	Bx of skin lesion each add'l 10 w/simple closure					82977	GGT		
				10060	I&D Abscess, simple or single					82948	Glucose (glucometer)		
				10061	I&D Abscess, complex/multi					80074	Hepatitis Panel, acute w / reflex		
				10140	Drainage, Hematoma					-HERPES	Herpes Simplex Virus 1 & 2 IgG AB		
CPT	Work Related Exams	Fee	DX	16000	Burn, 1st degree, initial tx, local					86701	HIV1 Ab w/confirmation (4259T)		
				16020	Debridement, small w/o anes					86677	H Pylori (send out only)		
				16025	Debridement, medium					87220	KOH		
				17000	Destruction benign or premalignant 1st lesion					80061	Lipid panel		
				17003	Destruction benign or premalignant 2-14 lesions					86308	Mono test		
				11730	Excision of nail, partial or complete					82272	Occult blood		
				10120	FB removal, simple SubQ tissue					88142	PAP test		
				10121	FB Removal, complex SubQ tissues					81025	Preg test urine		
				69200	FB Removal, External Auditory Canal					86403	Strep A, in-house		
				65205	FB Removal, Conjunctival, superficial					87070	Throat culture		
				65210	FB Removal, Conjunctival, embedded					81000	Urinalysis, Complete (in-house)		
				30300	FB Removal, Intranasal					81002	Urinalysis, Dipstick (in-house)		
				30901	Nasal Hemorrhage Control, Ant, simple					87086	Urine culture		
				30903	Nasal Hemorrhage Control, Ant, compl					87210	Wet Prep		
				11200	Removal of skin tags 1 - 15 lesions								
				11201	Removal of skin tags each add't 10 lesions								

CPT		Fracture Care		Fee	DX	CPT		Laceration Repair		Fee	DX	Diagnosis Codes / E Codes	
28660	Interphalangeal joint disloc, closed					12001	0 - 2.5 cm						
28470	Metatarsal, closed w/o manip.					12002	2.6 - 7.5 cm						
26750	Phalanges, distal finger, closed					12004	7.6 - 12.5 cm						
28490	Phalanges, great toe, closed					Scalp, Trunk, Extremities EXCL Hands & Feet - Intermediate							
28510	Phalanges, other toes, closed					12031	0 - 2.5 cm						
						12032	2.6 - 7.5 cm						
						12034	7.6 - 12.5 cm						
New / Est	Evaluation & Management	Fee	DX			Neck, Hands, & Feet - Intermediate							
99201   99211	E&M Level 1					12041	0 - 2.5 cm						
99202   99212	E&M Level 2					12042	2.6 - 7.5 cm						
99203   99213	E&M Level 3					12044	7.6 - 12.5 cm						
99204   99214	E&M Level 4					Face, Eyelids, Ears, Nose, Lips, Mucous Mem. - Simple							
99205   99215	E&M Level 5					12011	0 - 2.5 cm						
99382   99392	Well Child (1-4)					12013	2.6 - 5.0 cm						
99383   99393	Well Child (5-11)					12014	5.1 - 7.5 cm						
99384   99394	Well Child (12-17)					12015	7.6 - 12.5 cm						
99385   99395	Well Adult (18-39)					Face, Eyelids, Ears, Nose, Lips, Mucous Mem. - Intermediate							
99386   99396	Well Adult (40-64)					12051	0 - 2.5 cm						
99387   99397	Well Adult (65+)					12052	2.6 - 5.0 cm						
99354   99354	Ext Stay - 1 hour					12053	5.1 - 7.5 cm						
						12054	7.6 - 12.5 cm						

CIRCLE PAYMENT METHOD: \_\_\_\_\_ Initials: \_\_\_\_\_  
 Visa/MC/Amex/Debit/Cash/Check/CK# \_\_\_\_\_  
 Total Charges: \$ \_\_\_\_\_  
 Total Discount: \$ \_\_\_\_\_  
 Today's Payment: \$ \_\_\_\_\_  
 Balance Due: \$ \_\_\_\_\_

## Notice of Privacy Policies and 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.**

This Notice of Privacy Policies and Practices (the "Notice") tells you about the ways we may use and disclose medical information about you and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to PrimaMed Physicians Association, (the "Association") and its employees, and it is effective beginning April 14, 2003.

### **I. OUR OBLIGATIONS.**

We are required by law to:

- Make sure that the medical information we have about you is kept private, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the version of this Notice that is currently in effect at the time we acquire medical information about you.

### **II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be generic descriptions only, and not a list of every instance in which we may use or disclose medical information. Please understand that for these categories, the law generally does not require us to get your consent in order for us to release your medical information.

**A. For Treatment.** We may use medical information about you to provide you with medical treatment and services, and we may disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are providing or involved in providing medical care to you. For example, we will provide information about the results of your test to your physician and his or her office staff.

**B. For Payment.** We may use and disclose medical information about you so that we may bill and collect from you, an insurance company, or a third party for the services we provided. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we

may send a claim for payment to your insurance company, and that claim may have a code on it that describes your diagnosis.

**C. For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate our practice appropriately and make sure all of our patients receive quality care. For example, we may need to use or disclose your medical information in order to conduct certain cost-management practices, or to provide information to our insurance carriers.

**D. Quality Assurance.** We may need to use or disclose your medical information for our internal processes to determine that we are providing appropriate care to our patients.

**E. Utilization Review.** We may need to use or disclose your medical information to perform a review of the services we provide to ensure that the proper level of services are received by our patients, depending on their condition and diagnosis.

**F. Peer Review.** We may need to use or disclose medical information about you in order for us to review the credentials and actions of physicians to ensure they meet our qualifications and standards.

**G. Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

**H. Health Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

**I. Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law, or in accordance with your prior authorization.

**J. As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law.

**K. To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat to your health or safety or the health and safety of the public or another person. Such disclosure would only be to someone able to help prevent the threat, or to appropriate law enforcement officials.

**L. Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue

transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

**M. Research.** We may use or disclose your medical information to an Institutional Review Board or other authorized research body if it has obtained your consent as required by law, or if the information we provide them is “de-identified”.

**N. Military and Veterans.** If you are or were a member of the armed forces, we may release medical information about you as required by the appropriate military authorities.

**O. Worker's Compensation.** We may release medical information about you for your employer's worker's compensation or similar program. These programs provide benefits for work-related injuries. For example, if your injuries result from your employment, worker's compensation insurance or a state worker's compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

**P. Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose the following types of information to public health authorities, such as the Texas Department of Health. The types of information generally include the following:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information on certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

**Q. Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities

subject to government regulation which relates to health information, and compliance with civil rights laws.

**R. Lawsuits and Legal Proceedings.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

**S. Law Enforcement.** We may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. Examples of these situations are:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct in our office.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
- To report certain types of wounds or physical injuries (for example, gunshot wounds).

**T. Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

**U. National Security and Intelligence Activities.** We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**V. Inmates.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the correctional institution or the law enforcement official. This would be necessary for the institution to provide you with health care, to protect your health and safety and the health and safety of others, or for the safety and security of the correctional institution or law enforcement official.

### **III. OTHER USES OF MEDICAL INFORMATION.**

There are times we may need or want to use or disclose your medical information other than for the reasons listed above, but to do so we will need your prior permission. If you provide us permission to use or disclose medical information about you for such other purposes, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

### **IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.**

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following are a summary of those rights.

**A. Right to Inspect and Copy.** Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Association's HIPAA Officer at the address listed in Section VI. below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. The fee we may charge will be the amount allowed by state law.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Association will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

**B. Right to Amend.** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Association. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI. below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us, (ii) is not part of the information kept by the Association, (iii) is not part of the information which you would be permitted to

inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

**C. Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II. A., B., and C. of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures. To request this list of accounting, you must submit your request in writing to the Association's HIPAA Officer at the address set forth in Section VI. below.

Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**D. Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you in various situations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Association's HIPAA Officer at the address listed in Section VI. below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

**E. Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Association's HIPAA Officer at the address listed in Section VI. below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able to comply. Your request must specify how and where you wish to be contacted.

**F. Business Associates.** There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

**G. Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to Association's HIPAA Officer at the address set forth in Section VI. below.

**V. CHANGES TO THIS NOTICE.**

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our offices. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Association's HIPAA Officer at the address listed in Section VI. Below or by asking the office receptionist for a current copy of the Notice.

**VI. COMPLAINTS.**

If you believe that your privacy rights as described in this notice have been violated, you may file a complaint with the Association at the following address or phone number:

PrimaCare Medical Centers  
Attn: HIPAA Officer  
11910 Greenville Avenue, Suite 500  
Dallas, Texas 75243  
(214) 572-1124

To file a complaint, you may either call or send a written letter. The Association will not retaliate against any individual who files a complaint. If you do not want to file a complaint with the Association, you may file one with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Association's HIPAA Officer at the address or phone number listed above.

**ACKNOWLEDGEMENT OF RECEIPT**

By my signature below, I acknowledge that I have received the Association's *Notice of Privacy Practices* on or prior to my first visit following April 14, 2003.

**SIGNATURES:**

Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_

000130 000111  
11:29 AM 09/14/03

**Collin County Health Care Foundation  
Business Associate Contract  
in accordance with  
the Health Insurance Portability and Accountability Act  
And Incorporated Security Addendum**

This Agreement is entered into by and between Collin County Health Care Foundation (“CCHCF” and “Business Associate”) and PrimaMed Physicians Association d/b/a PrimaCare Medical Centers (“Provider”) and is intended to be effective as of the 1<sup>st</sup> day of January, 2010 (“Effective Date”).

**WITNESSETH:**

**WHEREAS**, CCHCF, as an entity involved in providing Health Care to the citizens of Collin County, Texas, and is a payor of medical services for individuals living in Collin County, Texas, and desires to become a Business Associate of Provider who is a treating physician, medical clinic, medical facility, or similar entity which provides health care services, treatment, or goods to individuals residing in Collin County, Texas; and

**WHEREAS**, CCHCF, as an entity involved in providing Health Care to the citizens of Collin, County, Texas, and is a payor of medical services, has a duty to ensure proper use of all funds extended to Provider for treating citizens of Collin County, Texas, and CCHCF participates in studies and research to aid in health care treatment and awareness of the citizens of Collin County, Texas, and therefore has a need to review certain data and information associated with medical services being paid to and provided by Provider; and

**WHEREAS**, Provider will make available and/or transfer to CCHCF certain data and information which may be Protected Health Information, in conjunction with goods, services, and treatment that are being provided by Provider to an individual whose medical treatment is paid by CCHCF, and therefore such data and information that is confidential must be afforded special treatment and protection; and

**WHEREAS**, CCHCF will have access to and/or receive from Provider certain Protected Health Information that can be used or disclosed only in accordance with this Contract and the HHS Privacy Regulations; and

**WHEREAS**, CHHCF and Provider hereby agree to comply in all of their business transactions with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (the “CFR”). In the event of conflicting terms or conditions in any other written or oral agreement entered by the parties, the terms of this Agreement shall govern.

*NOW, THEREFORE*, CCHCF and Provider agree as follows:

1. **Definitions.** The following terms shall have the meaning ascribed to them in this Section. Other capitalized terms shall have the meaning ascribed to them in the context in which they first appear.
  - a. "Contract" shall refer to this document.
  - b. BUSINESS ASSOCIATE" shall mean Collin County Health Care Foundation also referred to as CCHCF.
  - c. "CCHCF" shall mean the COLLIN COUNTY HEALTH CARE FOUNDATION, a Business Associate under this Agreement.
  - d. "Health Care Operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities are listed in the definition of "health care operations" at 45 CFR 164.501.
  - e. "HHS Privacy Regulations" shall mean the Code of Federal Regulations ("C.F.R.") at Title 45, Sections 160 and 164.
  - f. "Individual" shall mean the person who is the subject of the Protected Health Information, and has the same meaning as the term "individual" is defined by 45 C.F.R. 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
  - g. "Protected Health Information" shall have the same meaning as the term protected health "Protected Health Information" in 45 CFR 164.501, limited to the Protected Health Information created or received by Business Associate from or on behalf of CCHCF..
  - h. "Required by Law" shall have the same meaning as the term has in 45 CRT 164.501.
  - i. "Parties" shall mean PrimaMed Physicians Association d/b/a PrimaCare Medical Centers (Provider) and Collin County Health Care Foundation (BUSINESS ASSOCIATE and CCHCF)..
  - j. "Secretary" shall mean the Secretary of the Department of Health and Human Services ("HHS") and any other officer or employee of HHS to whom the authority involved has been delegated.
2. **Term.** The term of this Agreement shall commence as of the Effective Date, and shall expire when all of the Protected Health Information provided by Provider to Business Associate is destroyed, deleted from data indices, or returned to Provider pursuant to clause 7(i).

3. **Renewal Terms.** This Agreement may be renewed for additional terms following the expiration of the Term, by a writing executed by the Parties setting forth such renewal terms.
4. **Limits on Use and Disclosure Established by Terms of Contract.** CCHCF hereby agrees that it shall be prohibited from using or disclosing the Protected Health Information provided or made available by Provider for any purpose other than as expressly permitted by this Contract or as required by law. (ref. 164.504(e)(2)(i).)
5. **Stated Purposes for which CCHCF May Use or Disclose Protected Health Information.** The Parties hereby agree that CCHCF shall be permitted to use and/or disclose Protected Health Information provided or made available from Provider for the following stated purposes:

CCHCF shall be entitled to access and or use the minimum necessary Protected Health Information as is necessary for CCHCF to carry out its duties to ensure that CCHCF funds are used as stated in the attached and incorporated Collin County Health Care Foundation Agreement with the Provider for the provision of primary care to low income, uninsured United State's citizens and legal residents residing and domiciled in Collin County, Texas, and further to use such data and information to participate in studies and research for the benefit of health care and awareness to the benefit of the citizens of the United States, Texas, and Collin County, Texas. (ref. 164.504(e)(2)(i); 65 Fed. Reg. 82505.)

6. **Additional Purposes For Which CCHCF May Use Or Disclose Protected Health Information.** In addition to the Stated Purposes for which CCHCF may use or disclose Protected Health Information described in clause 5, CCHCF may use or disclose Protected Health Information provided or made available from Provider for the following additional purpose(s):
  - a. **Use of Protected Health Information for Management, Administration and Legal Responsibilities.** CCHCF is permitted to use Protected Health Information if necessary for the proper management and administration of CCHCF or to carry out legal responsibilities of CCHCF. (ref. 164.504 (e)(4)(i)(A-B))
  - b. **Disclosure of Protected Health Information For Management, Administration and Legal Responsibilities.** CCHCF is permitted to disclose Protected Health Information received from Provider for the proper management and administration of CCHCF or to carry out legal responsibilities of CCHCF, provided:

- i. The disclosure is required by law; or
  - ii. That CCHCF obtains reasonable assurances from the person to whom the Protected Health Information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, the person will use appropriate safeguards to prevent use or disclosure of the Protected Health Information, and the person immediately notifies the CCHCF of any instance of which it is aware in which the confidentiality of the Protected Health Information has been breached. (ref. 164.504(e)(4)(ii).
- c. **Data Aggregation Services.** CCHCF is also permitted to use or disclose Protected Health Information to provide data aggregation services, as that term is defined by 45 C.F.R. 164.501, relating to the health care operations of Provider or CCHCF. (ref.164.504(e)(2)(i)(B))

7. **CCHCF OBLIGATIONS:**

- a. **Limits on Use and Further Disclosure Established by Contract and Law.** CCHCF hereby agrees that the Protected Health Information provided or made available by Provider shall not be further used or disclosed other than is permitted or required by the Contract or as required by law. (ref. 45 C.F.R. 164.504(e)(2)(ii)(A))
- b. **Appropriate Safeguards.** CCHCF will establish and maintain appropriate safeguards to prevent any use or disclosure of the Protected Health Information, other than as provided for by this Contract. (ref. 164.504(e)(2)(ii)(B))
- c. **Reports of Improper Use or Disclosure.** CCHCF hereby agrees that it shall report to Provider **within two (2) days of discovery** any use or disclosure of Protected Health Information not provided for or allowed by this Contract. (ref. 164.504(e)(2)(ii)(C))
- d. **Subcontractors and Agents.** CCHCF hereby agrees that anytime Protected Health Information is provided or made available to any subcontractors or agents, CCHCF must enter into a subcontract with the subcontractor or agent that contains the same terms, conditions and restriction on the use and disclosure of Protected Health Information as contained in this Contract. (ref. 164.504(e)(2)(ii)(D))
- e. **Right of Access to Protected Health Information.** CCHCF hereby agrees to make available and provide a right of access to Protected Health

Information by an Individual. This right of access shall conform with and meet all of the requirements of 45 C.F.R. 164.524, including substitution of the words "CCHCF" with BUSINESS ASSOCIATE where appropriate. (ref. 164.504(e)(2)(ii)(E))

- f. **Amendment and Incorporation of Amendments.** CCHCF agrees to make available Protected Health Information available for amendment and to incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. 164.526, including substitution of the words "CCHCF" with BUSINESS ASSOCIATE where appropriate. (ref. 164.504(e)(2)(ii)(F))
- g. **Provide Accounting.** CCHCF agrees to make Protected Health Information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528, including substitution of the words "CCHCF" with BUSINESS ASSOCIATE where appropriate. (ref. 164.504(e)(2)(ii)(G))
- h. **Access to Books and Records.** CCHCF hereby agrees to make its internal practices, books, and records relating to the use or disclosure of Protected Health Information received from, or created or received by Provider available to the Secretary or the Secretary's designee for the purposes of determining compliance with the HHS Privacy Regulations. (ref. 164.504(e)(2)(ii)(H))
- i. **Return or Destruction of Protected Health Information.** At termination of this Contract, CCHCF hereby agrees to return, delete from its indices, or destroy all Protected Health Information received from, or created or received by CCHCF from Provider. CCHCF agrees not to retain any copies of the Protected Health Information after termination of this Contract. If return or destruction of the Protected Health Information is not feasible, CCHCF agrees to extend the protections of this Contract for as long as necessary to protect the Protected Health Information and to limit any further use or disclosure. If CCHCF elects to destroy or delete from its indices the Protected Health Information, it shall certify to Provider that the Protected Health Information has been destroyed. (ref. 164.504(e)(2)(ii)(I))
- j. **Mitigation Procedures.** CCHCF agrees to have procedures in place for mitigating, to the maximum extent practicable, any deleterious effect from the use or disclosure of Protected Health Information in a manner contrary to this Contract or the HHS Privacy Regulations. (ref. 164.530(f))

CCHCF agrees and understands that it must develop and implement a system of sanctions for any employee, subcontractor or agent who violates this Agreement or the HHS Privacy Regulations. (164.530(e)(1))

8. **Obligations of Business Associate**

Provisions for Business Associate to Inform Provider of Privacy Practices and Restrictions:

- a. Business Associate shall notify Provider of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associates use or disclosure of Protected Health Information.
- b. Business Associate shall notify Provider of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associates use or disclosure of Protected Health Information.
- c. Business Associate shall notify Provider of any restriction to the use or disclosure of Protected Health Information that Business Associate has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associates use or disclosure of Protected Health Information.

9. **Property Rights.** The Protected Health Information shall be and remain the property of Provider. CCHCF agrees that it acquires no title or rights to the Protected Health Information, including any de-identified Protected Health Information, as a result of this Contract.
10. **Termination of Contract.** Both parties agree that either party has the right to immediately terminate this Contract and seek relief under the Disputes Article if either party determines that either party has violated a material term of this Contract. (ref. 164.506(e)(2)(iii))
11. **Grounds for Breach.** Any non compliance by Business Associate with this contract or the HHS Privacy Regulations will automatically be considered grounds for Breach, if Business Associate knew or reasonably should have known of such non-compliance and failed to immediately take reasonable steps to cure the non compliance.
12. **Choice of Law.** This Contract shall be governed by the law of the State of Texas. The Parties also agree that for purposes of privacy rights, the HHS Privacy Regulation shall supercede all applicable state laws.
13. **Disputes.** Any controversy or claim arising out of or relating to the contract will be finally settled by compulsory arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"), except for injunctive relief as described below in article or in court of competent jurisdiction.

14. **Injunctive Relief.** Notwithstanding any rights or remedies provided for in this Contract, Provider retains all rights to seek injunctive relief in a court of competent jurisdiction to prevent or stop the unauthorized use or disclosure of Protected Health Information by CCHCF or any agent, contractor or third party that received Protected Health Information from CCHCF.

**MISCELLANEOUS:**

15. **Binding Nature and Assignment.** This Contract shall be binding on the Parties hereto and their successors and assigns, but neither Party may assign this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.
16. **Notices.** Whenever under this Contract one party is required to give notice to the other, such notice shall be deemed given if mailed by First Class United States Mail, postage prepaid, and addressed as follows:

**CCHCF:**

Candy Blair  
Collin County Health Care Services  
825 N. McDonald Street, Suite 110  
McKinney, TX 75069

**PROVIDER:**

PrimaMed Physicians Association  
d/b/a PrimaCare Medical Centers  
Attn: Jennifer Stephenson  
11910 Greenville Avenue, Suite 500  
Dallas, TX 75243

Either Party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

17. **Good Faith.** The Parties agree to exercise good faith in the performance of this Contract.
18. **Article Headings.** The article headings used are for reference and convenience only, and shall not enter into the interpretation of this Contract.
19. **Force Majeure.** Business Associate shall be excused from performance under this Contract for any period Business Associate is prevented from performing any services pursuant hereto, in whole or in part, as a result of an Act of God, war, civil disturbance, court order, labor dispute or other cause beyond its reasonable control, and such nonperformance shall not be grounds for termination.

20. **Attorney's fees.** Except as otherwise specified in this Contract, if any legal action or other proceeding is brought for the enforcement of this Contract, or because of an alleged dispute, breach, default, misrepresentation, or injunctive action, in connection with any of the provisions of this Contract, each party shall bear their own legal expenses and the other cost incurred in that action or proceeding.
21. **Entire Agreement.** This Contract consists of this document, and constitutes the entire agreement between the Parties. There are no understandings or agreements relating to this Agreement which are not fully expressed in this Contract and not change, waiver or discharge of obligations arising under this Contract shall be valid unless in writing and executed by the Party against whom such change, waiver or discharge is sought to be enforced.
22. **Security Addendum.** Pursuant to the requirements of the Security Regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 ("Security Rule") found at 45 CFR Part 164. The Provider and CCHCF agree to assume the following obligations regarding electronic Protected Health Information (e-PHI):
  - a. CCHCF and Provider agree to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the e-PHI that it creates, receives, maintains or transmits.
  - b. CCHCF and Provider will ensure that any agent, including a subcontractor, to whom it provides e-PHI that was created, received, maintained or transmitted agrees to implement reasonable and appropriate safeguards to protect the confidentiality, security, and integrity of e-PHI.
  - c. CCHCF and Provider agree to alert the other party of any security incident (as defined by the HIPAA Security Rule) of which it becomes aware, and the steps it has taken to mitigate any potential security compromise that may have occurred, and provide a report of any loss of data or other information system compromise as a result of the incident.
  - d. CCHCF and Provider agree to termination of the BA Agreement if either party reasonably determines that either party has violated a material term of this Amendment.

IN WITNESS WHEREOF, Provider and CCHCF have caused this Contract to be signed and delivered by their duly authorized representatives, as of the date set forth above.

PrimaMed Physicians Association  
d/b/a PrimaCare Medical Centers  
("PROVIDER")

By: Jennifer Stephenson  
Print Name: Jennifer Stephenson  
Title: Executive Director

Collin County Health Care Foundation ("CCHCF and  
Business Associate")

By: Keith Self  
Print Name: Keith Self  
Title: President of CCHCF

11:00 AM 11/11/09