

10208 Cerny Street - Suite 308 | Raleigh, NC 27617 | P 919-797-0550 | F 919-381-4621

FINANCIAL POLICIES: UNLIMITED MEMBERSHIP

Thank you for choosing Sentinel Primary Care. We ask that you review and accept our financial policies prior to provision of services.

Instructions: Please review each part of our financial policies, initial each one, and sign at the bottom of the form.

_____ **A. Membership fees:** Arrangement to pay membership fees is due at the first office visit. Membership fees may be paid in a yearly sum or in monthly installments. These fees may be paid by credit card, check, cash, or by automated bank draft. Membership fees are listed on Sentinel Primary Care's website, sentinelprimarycare.com.

The membership year begins in the first month of membership. If your fee bracket changes during a member-year the total annual fee will be prorated according to the months in each age bracket with the charge for the birth month being the higher of the two charges.

_____ **B. Initial membership commitment is 6 months.** After the initial six months, membership can be cancelled as below. If you withdraw from the practice prior to six months the balance of your membership fees for the initial 6 months will be due immediately. After the initial 6 months membership is month-to-month.

Departure from the practice: either party can notify the other by written, electronic, or verbal means of their intent to terminate membership at Sentinel Primary Care. In the event that you withdraw from Sentinel Primary Care within the first 6 months of membership, the balance of your membership fees for the initial 6 months will be due immediately. If an annual fee was paid as a one-time sum, we will refund the fees that would have accrued in months 7-12. In the event that you leave Sentinel Primary Care after the first 6 months of membership, we will discontinue monthly membership fee payments in first month following departure. If an annual fee was paid as a one-time sum, we will refund the prorated remaining amount less 1/12th of the annual membership fee per month or portion of a month of membership during that membership year. The remaining amount will be returned by check or credit card refund at the discretion of Sentinel Primary Care. Please allow 30-45 days for processing. If you leave Sentinel Primary Care and subsequently seek to rejoin the practice, Sentinel Primary Care has the discretion to require a 12-month waiting period before you rejoin the practice.

Dismissal from the practice: In the event that Sentinel Primary Care dismisses you from the practice, we will discontinue monthly membership fee payments in first month following dismissal. If an annual fee was paid as a one-time sum, we will refund the prorated remaining amount less 1/12th of the annual membership fee per month or portion of a month of membership during that membership year. Please allow 30-45 days for processing.

Any outstanding balance with Sentinel Primary Care will be due immediately upon departure or dismissal from the practice.

Hardship consideration: Sentinel Primary Care recognizes that unforeseen financial circumstances may arise that make the membership fee a significant burden. If you are unable to pay your membership fee or if you fall behind on payments, please discuss your situation with the Practice Manager so that we can consider arrangements for an alternate payment schedule. If no mutually agreeable remedy can be found, or if you cannot fulfill the terms of an alternate payment schedule, it may be necessary for you to withdraw from Sentinel Primary Care.

Depending on your circumstances, you may be eligible for Sentinel Primary Care's charitable care program. We will review each request on a case-by-case basis.

If you fall two months behind in payments without making arrangements with Sentinel Primary Care this will indicate your withdrawal from the practice; in this case we will provide 30 additional days of emergency care only, after which your relationship with Sentinel Primary Care will terminate. Additionally, if you fall two months behind in payments without making arrangements during the first 6 months of membership then the balance of your membership fees for the initial 6 months will be due immediately.

Any delinquent fees or outstanding balance may be submitted for collections, along with reasonable attorney fees and collection cost.

C. Policy for Filing Insurance: We do not participate in any insurance plans. If requested, we can provide a statement of the value of medical services received at Sentinel Primary Care.

Each time you come to our office, please bring with you a current insurance ID card and a valid government issued photo identification card (e.g. driver's license, passport). In some cases, your insurance plan may not cover the services we order or refer for, or may determine that some of the services are not medically necessary. Your insurance company's rejection of all or part of your medical insurance claim does not relieve you of your financial obligation.

D. Outside services: Our bills for service do not include radiology services, pathology studies, outside laboratory tests, physical therapy, or any other services provided or obtained outside of the practice. If you receive any of these services, you will receive a separate bill from the facility where the services were performed.

E. Membership in Sentinel Primary Care is Not Insurance: Sentinel Primary Care is a primary care medical office, with services provided according to the "Services" page of Sentinel Primary Care's website, <https://sentinelprimarycare.com/primary-care-services-raleigh/>

FEE INFORMATION

Copying Medical Records (in North Carolina):

- \$0.25 per page
- Minimum charge: \$10.00
- Electronic Copy of Designated Record Set within Medical Records Requested Under HIPAA: \$6.50

Patient Authorization: My initials above and my signature below signify that I understand and agree to the policies above.

Patient/Guardian Signature

Date

Patient/Guardian Printed Name

Patrick O'Connell, MD

Date



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SUPPLEMENTAL NEW PATIENT MEDICAL INFORMATION

Welcome to Sentinel Primary Care! In addition to the information you filled out online, please take a moment to give a few additional details:

Date: _____

Name: _____ Date of Birth: _____

How should we address you? _____

Preferred pharmacy: _____

List significant *prior* medical problems (ie, inactive medical problems from the past):

_____	_____
_____	_____
_____	_____

Specialists you currently see:

Specialty: _____	Specialist's name and practice: _____
Specialty: _____	Specialist's name and practice: _____
Specialty: _____	Specialist's name and practice: _____
Specialty: _____	Specialist's name and practice: _____

Medical problems among your blood relatives:

Do any diseases run in your family? Please specify: _____

Social Information:

Marital status: ☐ Single ☐ Married ☐ Long-term relationship ☐ Divorced ☐ Widowed

Spouse/partner's name: _____

Children: Names and Ages: _____

Hobbies, activities: _____

Religion: _____

Other important things in your life: _____

Preventive Care:

Vaccines:

Hepatitis A series ☐ Yes ☐ No When? _____

The original shingles vaccine (zostavax) ☐ Yes ☐ No When? _____

The new shingles vaccine (shingrix) ☐ Yes ☐ No When? _____

Cancer Screening: When was you last (if applicable):

Lung cancer screening: Date: _____ Findings: _____

Have you been screened for?

Hepatitis C: ☐ Yes ☐ No

HIV: ☐ Yes ☐ No

Abdominal aortic aneurysm: ☐ Yes ☐ No



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COMMUNICATING WITH THE PRACTICE

____(initial) **NORMAL BUSINESS HOURS**

Medical Emergencies: If you are experiencing a medical emergency please call 911 or go immediately to the emergency room.

For time sensitive concerns, please call the office directly.

For routine concerns, an appointment request, prescription refills or other requests, please contact us and we will address your concerns during regular business hours.

____(initial) **AFTER HOURS**

Medical Emergencies: If you are experiencing a medical emergency please call 911 or go immediately to the emergency room.

If you need medical assistance after normal office hours, please call the office at (919) 797-0550 and follow instructions to reach the covering provider. Expect a return phone call within 30 minutes.

NON-SECURE MEANS OF COMMUNICATION

Sentinel Primary Care provides the option to communicate using text messages and email. These methods provide greater convenience but less security than a password-protected portal. Sentinel Primary Care will make reasonable efforts to keep email and text communications confidential and secure but cannot guarantee the confidentiality of email and text communications, and the possibility exists of third parties gaining access to these communications. All email and text communications including attachments/images will become part of the medical record and will be stored with the same security measures as all other medical records.

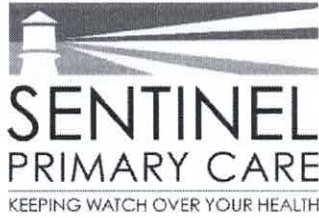
Email and text messages are not to be used for urgent issues. If you do not receive a response to a text message or email, then please contact the practice by phone.

☐ I consent communication through potentially nonsecure methods

☐ I DO NOT consent to communication through potentially nonsecure methods

Signed _____ Date _____

Full Name _____



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**REQUEST FOR ACCESS TO ELECTRONIC HEALTH RECORDS FOR SENTINEL PRIMARY CARE
- IN OFFICE CONSENT -**

Patient Name: _____ Date of Birth: ____/____/____

Select one:

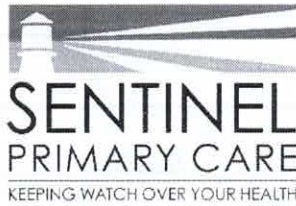
☐ I, (Patient's Full Name) _____,
hereby **AUTHORIZE** Sentinel Primary Care to access ALL to my electronic health information through UNC
CareLink, WakeMed CareLink, and Duke MedLink.

☐ I, (Patient's Full Name) _____,
hereby **DENY** access to Sentinel Primary Care to access ALL to my electronic health information through UNC
CareLink, WakeMed CareLink, and Duke MedLink.

CareLink/MedLink allows Sentinel Primary real-time electronic access to your medical history, including previous diagnoses, test results, medications, allergies, progress notes and other crucial information, without having to wait for these records to be transferred from one facility to another.

Patient Signature: _____

Date Signed: _____



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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (HIPAA)

Instructions: Sentinel Primary Care is HIPAA compliant. We take seriously our legal obligation to protect confidential patient information. We give all patients the opportunity to read our HIPAA Notice of Privacy Practices (NPP) and ask for their written acknowledgment. Please help us maintain our respect for patient privacy and comply with the law by completing this authorization form giving us permission to discuss patient information with specific individuals such as spouses, other adults, children, etc.

I have had the opportunity to read Sentinel Primary Care's HIPAA Notice of Privacy Practices regarding the Use and Disclosure of Protected Health Information (PHI). I understand that I may refuse to sign this authorization to release PHI and that my refusal to sign will in no way affect my treatment, payment, enrollment in a health plan, or eligibility for benefits. I also understand that my signature is required in order to complete this request.

Sentinel Primary Care may use and disclose either all of my PHI or specific components of my PHI as specified below only for the specific purpose identified below and for the time period specified below or until the completion of the event for which I have provided the authorization. My authorization is not a blanket permission to use and disclose PHI.

At all times, I retain the right to revoke this authorization to use and disclose PHI. Should I wish to exercise this right, I will submit a written request to the Sentinel Primary Care Practice Administrator.

I understand that the party that receives my PHI may re-use or re-disclose the information received. At that point, the PHI may no longer be protected under federal or state confidentiality rules.

I understand that Sentinel Primary Care may charge a fee for copying the medical records for which I have provided authorization for use and disclosure.

I have read the information related to use and disclosure and understand that I may request a copy of this form if desired.

Medical Record Number: (to be filled in by practice): _____

Patient Name: _____

Date of Birth: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

As the patient or the individual authorized to act on behalf of the patient, I authorize the use and disclosure of the following protected health information (PHI) relating to me as described below.

I, _____ (Patient name) hereby authorize Sentinel Primary Care to release the following information:

_____ Entire Chart _____ Mental Health

_____ Office Notes _____ Drug and Alcohol Addiction

_____ Pathology Report _____ HIV

_____ Lab Test Results _____ Other: _____

Release information to: (name) _____ (relationship to the patient) _____

(name) _____ (relationship to the patient) _____

Time Period: (e.g. calendar year 20XX; hospitalization, all dates, etc.): _____

Signature of Patient or of Individual Authorized to Act on Patient's Behalf:

Patient/Guardian Signature

Date

Patient/Guardian Printed Name



KEEPING WATCH OVER YOUR HEALTH

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE POLICY CAREFULLY.

This notice describes the privacy practices of Sentinel Primary Care in the locations where we provide care for patients. Currently we provide the majority of care in our office.

Our Pledge Regarding Health Information

We understand that information about you, your health, and your health care is personal. We are committed to protecting the security of that information and your protected health information (PHI), and to preventing its disclosure without your authorization.

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or by others working in this office. This notice tells you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI that we keep about you and explain our obligations regarding the use and disclosure of your PHI.

By law, we are required to:

- Make sure that health information that identifies you is kept private
- Provide you with this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect
- Notify you if there is a security breach of protected health information (PHI) except when the PHI is encrypted and is disposed of securely

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information. Within each category, we have provided a list of examples.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to physicians, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices; at the hospital if you are hospitalized under our supervision; or at another physician's office, lab, pharmacy, or other health care provider where we may have referred you for x-rays, laboratory tests, prescriptions, or other treatment purposes. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the physician may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. The information may include monies that we have received from you, an insurance company, or a third party.

For example, we may need to provide information about your office visit to your health plan information so the plan can either pay us or reimburse you for the visit. We may also tell your health plan about a treatment before you receive it so that we can obtain prior approval, if required, or determine if your plan will cover the treatment. If we provide a service for which you pay in full out-of-pocket and you request that we not send PHI to your insurance company, we are obligated to comply with your request except when the information is needed to comply with the law.

For Health Care Operations: We may use and disclose protected health information about you for the operation of our health care practice. These uses and disclosures are necessary to run our practice and to make sure that all our patients receive quality care. For example, we may use health information in a general review of our treatments and services or, more specifically, to evaluate the performance of our staff in caring for you. We may also combine the health information of many patients to decide what improvement we could make, what additional services we should offer, what services are not needed, or whether certain new treatments are effective. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who are our specific patients.

Marketing: We will seek and obtain your prior written authorization for all written communications to you regarding treatment and healthcare operations where we have received financial remuneration from (or on behalf of) a third party in exchange for sending the communication; and the communication is intended to encourage purchase or use of a product or service offered by the third party. This requirement may apply to appointment reminders, treatment reminders, alternative treatments, and healthcare products and services. The requirement does not apply to face-to-face communications; promotional gifts of "nominal" value; prescription refill reminders or other communications about a drug or biologic that is being prescribed for you if the financial remuneration that receive is reasonably related to our cost for making the communication; communications about general health; and communications about government or government-sponsored programs.

Health-Related Services and Treatment Alternatives: We may use and disclose protected health information (PHI) to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to send you this information or if you wish us to send this information to a different address.

Appointment Reminders: We may use and disclose protected health information to contact you to remind you that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know your preferred method of contact for appointment reminders (e.g. home phone, cell phone, email).

Fundraising Activities: From time to time we may use your protected health information (PHI) to contact you in an effort to raise money for a not-for-profit organization. We only will utilize contact information, such as your name, address, and phone number. In these instances, we will give you the option to opt out of the fundraising communication.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank or to organizations that handle organ procurement or organ, eye, or tissue transplantation, as necessary to facilitate organ or tissue donation and transplantation

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

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Such disclosure, should it occur, would be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated or discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs, if applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following:

- The prevention or control of disease, injury, or disability
- The reporting of births and deaths
- The reporting of child abuse or neglect
- The reporting of reactions to medications or problems with products
- The notification of people about recalls of products they may be using
- The notification of a person or organization required to receive information on Food and Drug Administration-regulated products
- The notification of a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- The notification of 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)

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. Examples of oversight activities are audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information upon request by a law enforcement official:

- In reporting certain injuries, as required by law: gunshot wounds, burns, dog bites, and injuries to perpetrators of crime
- In response to a court order, subpoena, warrant, summons, or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person (name and address, date of birth or place of birth, social security number, blood type or Rh factor, type of injury, date and time of treatment and/or death, if applicable, and a description of distinguishing physical characteristics)
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our facility
- In emergency circumstances to report a crime; the location of a crime or victims; or the identity, description, or location of a person who committed a crime

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner or health examiner. This release may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy health information such as medical and billing records that may be used to make decisions about your care. In order to request inspection and copying of health information that may be used to make decisions about you, submit a written request to the Practice Manager. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request a review of the denial. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. Our practice will comply with the outcome of the review.

- **Right to Request Information in a Form of Your Choosing:** You have the right to request the provision of protected health information (PHI) in a form of your choice such as paper or electronic. We will grant or deny the request within 30 days, and we may at times request a 30-day extension period. If any of the protected health information (PHI) is stored off-site, we will respond to your request within 60 days. We may charge you a reasonable, cost-based fee for preparing the information that you request.

- **Right to Request that We Send Information to Other Designated Parties:** You have the right to request that we send copies of your protected health information (PHI) to other designated parties, provided that you submit a written signed request, designating the name, identity, and correct address of the designated recipient.

- **Right to Amend:** If you believe that health information we have about you is incorrect or incomplete, you may ask that we amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, submit a written Request for Correction/Amendment of Protected Health Information form to the Practice Manager. Include the change/amendment that you want and your reasons on the form. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice

- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those to whom we disclose information as previously specified.

- **Right to an Accounting of Disclosures:** You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, submit your request in writing to the Practice Manager. Your request must state a time period that may not be longer than 6 years and may not include dates prior to the opening of the practice. The first list you request within a 12-month period will be free. For additional lists, we may charge you 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. We will mail you a list of disclosures in writing within 30 days of your request. If we are unable to provide you with this information within 30 days, we will notify you of that fact and inform you of the date by which we can supply the list. This date will not be more than 60 days from the date you made the request.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information that we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we withhold your information from a specified nurse or that we not disclose to your spouse information about a surgery you had. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

If we do agree, we will comply with your request, unless the information is needed to provide emergency treatment for you. To request a restriction, make your request in writing to the Practice Manager on the Authorization to Use and Disclose PHI form. Specify the information that you want to limit and to whom you want the limits to apply.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, make a written request in writing to the Practice Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

- **Right to Request Withholding of Disclosures Health Plans:** If you pay out-of-pocket in full for a service that we provide, you may request that we withhold from the payer disclosure of information on that service. We are obligated to comply with that request unless disclosure is otherwise required by law.

- **Right to Request Withholding of Use and Disclosure of Psychotherapy Notes:** You may request that we withhold use and disclosure of psychotherapy notes related to care we provide for you.

- **Right to Be Notified Should there Be a Breach:** You have the right to receive notice from us regarding a breach in disclosure of protected health information (PHI).

- **Right to a Paper Copy of This Notice:** You have the right to request a paper copy of this notice at any time. The office staff can provide the Notice for you.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as for any information we receive in the future. We will post a copy of the current Notice both at our office and on our Website. You may request a copy of our most current notice at any time.

Complaints

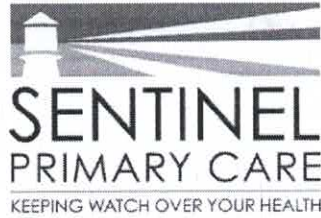
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services in Washington, DC. To file a complaint with us, complete our Patient Comment and Privacy Complaint form (add link). Submit all complaints in writing to the Practice Manager. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information (PHI) about you for the reasons covered by your written authorization. We cannot revoke any disclosures that we have already made with your permission. We are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of This Notice

We will request that you sign a separate form acknowledging that you have received a copy of this notice. If you choose not to sign or are unable to sign, a staff member will sign his or her name and date. This acknowledgment will be filed with your records.



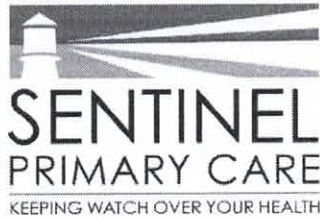
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**WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF HIPAA
NOTICE OF PRIVACY PRACTICES**

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Practice Manager.

I, _____ have received a copy of Sentinel Primary Care's Notice of Privacy Practices.

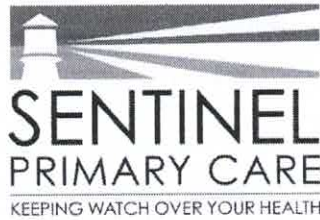
Patient Signature: _____ Date: _____



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MISSION STATEMENT

Our mission is to provide high-quality primary care services, giving generous time and personal attention to promote health through long-term relationships; to provide the same care to those with limited resources; to provide care that upholds the dignity of the person. Trusting in the love & mercy of God and embracing the call to love one's neighbor as oneself, we at Sentinel Primary Care work to put love in action. We offer services to all persons in the community in need of health care. We are committed to providing quality care in fidelity to the organization's Statement of Faith, honoring the life and dignity of every person we serve.



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FOUNDATIONAL PRINCIPLES

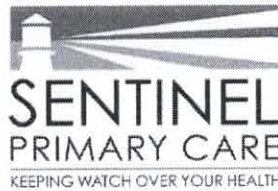
We desire to provide compassionate medical care according to the highest standards of professional excellence, serving people of all faiths or none at all, all for the glory of God.

We affirm the two greatest commandments: "You shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength. This is the great and first commandment. And the second is like it: You shall love your neighbor as yourself." Matthew 22:37-39. We believe that medical care is, at its core, a work of love.

We believe in the right of each individual to conduct his or her life in accordance with conscience, religious faith, and moral convictions. This right extends to the workplace. Accordingly, we strive to align our medical practice with our Christian (and more specifically Catholic) faith.

With these principles in mind, therefore:

- We honor, protect, and defend the sanctity of human life at all stages, from conception through natural death;
- We give a portion of our professional services to those who are otherwise without the resources to provide healthcare for themselves;
- We do not prescribe contraceptive or abortifacient medications;
- We do not recommend or refer for sterilization procedures such as vasectomies or tubal ligations;
- We do not recommend or refer women for abortions; instead, we refer women inquiring about such services to local crisis pregnancy centers;
- For matters concerning sexual and/or reproductive health, we counsel our patients to follow the traditional Christian teaching of abstaining from sexual activity outside of the marriage, defined as the union of one man and one woman (according to the sex at birth). We do not encourage or facilitate attempts to alter the sex assigned at birth.



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ADDITIONAL CLINIC INFORMATION

1. **Rescheduled Appointments and No-Shows:** We understand that plans change and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. Sentinel Primary Care has a cancellation policy of one business day. We do not charge a fee for missed appointments or short-notice cancellations, but repeated missed appointments or cancellations within 24 hours may lead to dismissal from Sentinel Primary Care.
2. **Property Damage:** We expect normal wear and tear on office equipment and furniture. However, you will be financially responsible for repair or replacement for damage that you cause to office property. Sentinel Primary Care welcomes children, but please supervise them to prevent damage to office property as you will be responsible for repair or replacement.
3. **Recording Devices:** We prohibit the use of recording devices of any kind without prior written consent from the Practice Manager or Executive Director
4. **Mission Statement and Foundational Principles:** I have received and have reviewed the Sentinel Primary Care's Mission Statement and Foundational Principles. I understand that, as indicated in these documents, there are certain limits to the care provided at Sentinel Primary Care that flow from its religious principles. I have been given an opportunity to ask Dr. O'Connell any questions about Sentinel's religious principles and about how these principles relate to medical care at Sentinel. I desire to become a member of a medical practice marked by these principles.

Patient/Guardian Signature

Date

Patient/Guardian Printed Name

