NOTICE OF PRIVACY PRACTICES

Please read this carefully. It concerns your individual, private healthcare information and how this information may be used and disclosed by this office and how you can get access to this information. Please review it carefully.

1) We have a legal, ethical and moral obligation to protect your confidentially. Any information about you and/or your family will be held strictly confidentially by all employees. No discussions about you outside of the patient care framework will be allowed, and any conversation between staff members that pertains to delivering you quality care will be held in a confidential and professional manner.

2) In order to provide quality care to you, as well as operate this office in an efficient manner, we will need to access your private health care information for the purposes of treatment, payment and operations (such as quality assurance). In using this information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPPA").

3) Specifically, we will need to disclose your private information under the following circumstances:

   a) Sharing information for purposes of treatment: We will share information with all members of your treatment team, both within this office and with other providers (personal and Institutional) in order to provide you with the quality care and the education/wellness programs.

   b) Sharing of information for the purposes of payments: We will share all necessary information with your insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, Americaide, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as our representatives involved in the billing process (including, but not limited to claims representatives, data warehouses, billing companies, etc.).

   c) Sharing of information for purposes of operations: We will share all information necessary for ongoing operations of this office, including (but not limited to) credentialing processes, peer review, accreditation and compliance with all federal and state laws.

4) Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

5) Your specific authorization will be required for the release of any information not included above. Your authorization will need to be in writing and it will be specific to the disclosure requested.

6) This office will not release any information other than those incidents described above unless disclosure is required by law, a court, a legal process or government agencies.

7) You have the right to inspect and copy your protected information, amend your record, have reasonable requests for confidential communications accommodated and may obtain an accounting of disclosures. All other rights afforded to you by state and federal law will be honored as they are created. This office will attempt to comply with any of your requests if feasible. Please contact the Privacy Officer if you have any questions about your rights, or with any other privacy related questions you may have.

8) This office will continue to respect you and your family's privacy and confidentiality. The Privacy Officer is available to discuss any questions or concerns you may have regarding the security and privacy of you and/or your family's private health information.

- I have received a copy of the "Notice of Privacy Practices" which details my rights of privacy.
- I consent and authorize Pro Neuro Health, to utilize my PHI (Private Health Information), for health/wellness and treatment purposes as well as for internal administrative purposes.
- I consent and authorize the releasing of my PHI from Pro Neuro Health to another service organization in direct regard to my health/wellness and treatment being performed by Pro Neuro Health.
- I consent and authorize Pro Neuro Health to discuss, document, provide and/or request PHI to/from another organization for means of collection of payment or reimbursement.
- I consent and authorize Pro Neuro Health to discuss, document, provide and/or request PHI from another organization for administrative purposes.
- I have the right to deny and/or limit the use of my PHI. Should my requests and or choices affect my care as deemed necessary by the doctor, I understand that I may be released as a patient of Pro Neuro Health.

Patient Name (printed)_____ Responsible Party (signature)_____

Date _____