CHRISTINA PABERS, PhD, MA TCM, L.Ac
215 E. Daily Dr. #12, Camarillo, CA 93010 Phone (805) 383-0636 FAX (805) 384-9091

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, how you can get access to this information, your rights concerning your health information and our responsibilities to protect your health information. Please review it carefully.

State and federal laws require us to maintain the privacy of your information and to inform you about our privacy practices by providing you with this notice. We are required to abide by the terms of this **NOTICE OF PRIVACY PRACTICES**. This Notice will take effect on September 20, 2013 and will remain in effect until it is amended or replaced by us. We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting us.

Treatment: While we are providing you with health care services, we may share your **Protected Health Information (PHI)** including **Electronic Protected Health Information (ePHI)** with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals with have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may also be disclosed to your family, friends and/or other persons you choose to involve your care only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” of your protected information if the disclosure was made for purposes other than providing services, payment and or business operations. In light of the increasing use of Electronic Medical Records technology (EMR), the HITECH Act allows you the right to request a copy of your health information in and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan. if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider’s refusal of an individual’s request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of other.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medication, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communication with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). “Sale of PHI” does not include disclosures for public health, certain research purposes, treatment and payment and for any other purpose permitted by the Privacy Rule, where the only remuneration received is “a reasonable cost-based fee” to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of “sale”.

Appointment Reminders: We may use health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact us for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. For chart records beyond 10 pages, a fee of $0.25 per copy will be charged and shipping fees will be charged if you request them to be mailed.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that nay acquisition access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. If we feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.
How to Contact Us:

Practice Name: Christina Pabers, PhD, MA TCM, L.Ac
Privacy Officer: Susan Caudel
Telephone Number: 805 383-0636 Email: pabersoffice@protonmail.com Address: 215 Daily Dr. #12, Camarillo, CA 93010

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HIPAA DISCLOSURES and
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Federal Government has established a new law known as HIPAA (Health Insurance Portability & Accountability Act). We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of your **Protected Health Information (PHI)** and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We have prepared a detailed notice describing how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. This notice will be offered to you at your office visit and is available for you to read at any time in our office.

Following is a brief summary of your rights:

- Notice – The right to be informed about uses and disclosures of PHI.
- Choice – The right to deny permission of certain uses and disclosures of PHI.
- Inspection – The right to review your PHI.
- Amendment – The right to request changes to PHI that is inaccurate or incomplete.
- Audit – The right to receive an audit or accounting of certain classes of disclosures of your PHI.
- Redress – The right to complain about perceived violations of your privacy and to have these complaints taken seriously.

We have taken formal measures to comply with this law, and as always, our first concern is to provide each patient with the highest quality medical care possible.

I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be available in the reception area and that I may request a copy of any amended Notice of Privacy Practices at any time.

PATIENT/GUARDIAN NAME: ____

PATIENT ADDRESS: ____

SIGNATURE: ____

DATE: ____________________

If not signed by the patient, please indicate:
Relationship to patient:
(   ) Parent or guardian of minor patient
(   ) Guardian or conservator of an incompetent patient
(   ) Beneficiary or personal representative of deceased patient.

Name of Patient: ____

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Insurance Billing Agreement and Payment Agreement

Please read carefully the following information. Initial each area and then sign below.

SCHEDULING AND FEES:
In an effort to provide quality care, we see a limited number of patients in a day. Please provide 24 hours notice for cancellations and changes. Unless the space can be filled, we reserve the right to charge the full price for all missed or rescheduled appointments within less than 24 hours' notice. You are responsible for all bank fees incurred from returned checks. Payment is due upon services rendered. We accept: Visa, MasterCard, Debt Cards, Check & Cash.

Initial_____________

RELEASE OF INFORMATION:
By initialing below, you authorize the release of:

A. Any information necessary to process a claim with your insurance company
B. Any Information that you may request to be sent to any of your allied health care practitioners. Please see our staff for additional information regarding this issue.
C. Any verbal discussion that may be necessary between our office and your allied health care provider.

Initial_____________

VOLUNTARY TERMINATION OF CARE:
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately, will be personally responsible for payment, regardless of your insurance coverage.

Initial_____________

Digital Communication
Very often as a method of providing ongoing support to patients, it is necessary to email health plans and advice and to answer emailed questions. Texting and voice texting back and forth for the purpose of providing ongoing support is also common. We also provide reminder calls and or texts for appointments. I agree to receiving these communications at the phone number and email address provided even though email and texting is more vulnerable to hacking and is potentially less private. Financial and sensitive identification numbers will not be included in these communications for your protection.

Initial _____________

Insurance Policies
We accept and bill both primary and secondary insurances. In most cases we are consider **out-of network.** Our staff will call to verify coverage and notify you of benefit coverage. However, it is not a guarantee of payment and you are ultimately responsible for all charges that may accumulate. **All herbal supplements and therapeutic massage are out-of -pocket charges as they may not be covered by most insurances.** "Assignment of Benefits" is located on the reverse

side of this page. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring full payment to our office immediately upon receipt.

Initial_____________

Insurance Policies Continued

I acknowledge that I am providing a co-pay and possibly co-insurance upon service rendered. This amount is a consistent but different amount from an out-of-pocket fee for service. The office of Christina Pabers will be billing my insurance and one of a few results may occur:

a. The insurance company may apply an amount toward the deductible.
b. The insurance company may reject the bill.
c. The insurance company may provide partial or full payment of the bill and send directly to the office of Christina Pabers.
d. The insurance company may send a check to the patient in their name. If this occurs, the patient is responsible for remitting the entire amount of the check to Christina Pabers.

If the insurance company pays the full or partial amount, the patient may be entitled to partial or a full refund. This must be discussed after the insurance moneys have been received by Christina Pabers. Refunds are only provided for the co-insurance amount and not the co-pay amount. If the insurance company rejects the bill or pays less than the standard fee the patient is responsible for paying the remainder of the bill.

Initial_____________

Consent to Release Confidential Patient Records

I, ______________________hereby authorize Acupuncture Natural Health Center/ Christina Pabers
Patient/Parent/Guardian

Located at 215 Daily Dr. #12, Camarillo, Ca 93010 to discuss and provide records to my health insurance company. This disclosure of records authorized herein is required for third party reimbursement and such disclosure shall be limited to the course of my diagnosis and treatment. This consent is subject to revocation by the undersign at any time except to the extent that this office has taken in reliance herein, and if not earlier revoked, it shall terminate one year after discharge.

Assignment of Benefits

I authorize payment of medical benefits for all services provided in the treatment of________________________ to be
Patient Name

paid directly to Christina Pabers, Located at 215 Daily Dr. #12, Camarillo, Ca 93030.

Thank you for choosing us for your care. My staff and I look forward to working with you. ***I have read the above policies and agree to all terms.*** Those areas of this document that <u>do not</u> have initials <u>do not</u> apply to this agreement.

_____________________________________ _________________________
Patient Date

__________________________ __________________________
Guardian Date