NOTICE OF PRIVACY POLICIES

Verity Acupuncture is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers;
- Information we receive from third-party payers.

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and healthcare operations.

You may specifically authorize us to use Protected Health Information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your protected health information.

Marketing: This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters, or appointment reminders by calls, postcards, or letters. This office may send you information to support your health care, information about alternative treatments, and health-related services that may be of interest to you. Please advise this office if you do not wish to receive such communications, and we will not use or disclose your information for such purposes. If you do not wish to receive such communication, you must advise our office in writing at our contact address.

Disclosure: This office may use or disclose your Protected Health Information when required by law. Without your consent or authorization, this clinic may disclose information about you only for the following purposes:

- To a public health agency, for the purpose such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or if it appears necessary to prevent serious harm to you or others.
- To health oversight authorities for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United State military, national security or intelligence, or Foreign Service, to your authorized superiors or other authorized federal officials.

We may not disclose information about you for any other purpose without your written authorization, provided separately from your written consent.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have a right to receive all notices in writing.
5. You have the right to request that we amend your Protected Health Information; the request must be in writing.

I, ____ (Printed Name),

have read, reviewed, understand, and agree to the Notice of Privacy Policies for healthcare and/or other services provided through this office.

This office has attempted to provide each patient with a Notice of Privacy Policies.

X

Patient Signature or Signature of Parent/Guardian if under the age of 18 **Date** *HIPAA Form A*

PATIENT'S CONSENT

FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, ______________________ (Printed Name) give consent to Verity Acupuncture
the use and disclosure of my individual identifiable health information or Protected Health Information for the following specific purposes:

A. Providing treatment to me;
B. Relating to the payment of the service this office has rendered to me;
C. The general administrative operations this practice provides to me.

The Purpose of this Consent:

Protected Health Information is any information which includes:

A. Demographic information;
B. Information gathered by this practice as it relates to my past, present or future physical or mental health or condition;
C. Information gathered by this office for past, present or future payments for providing the healthcare services;
D. Healthcare operations will include quality assessment activities, credentialing, business management, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Clinic, but the Clinic is not required to agree to these restrictions. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

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Signature of Patient/Personal Representative or Signature of Parent/Guardian if under the age of 18 Date

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Description of Personal Representative's Authority