Palo Alto Neurofeedback

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contact@paloalotneurofeedback.com
www.paloaltoneurofeedback.com

Patient Privacy

NOTICE OF PRIVACY PRACTICES, EFFECTIVE DATE May 1st, 2014

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.

If you have any questions about this notice, please contact Kimberly Bell at (650) 948-4900.

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, plan for future care or treatment, and billing related information. This is known as protected health information.

My Responsibilities**:** I am required by law to maintain the privacy of your protected health information and to provide you with a description of my privacy practices and legal duties with respect to your protected health information.

This notice covers the privacy practices of my employees, contract staff and myself.

Whenever I use a disclosure of protected health information, I will abide by the terms of this notice of privacy practices. Please sign and return at your earliest convenience the acknowledgment of receipt "form", which will acknowledge your receipt of this notice.

USES AND DISCLOSURES:

1. **HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU. (NO AUTHORIZATION REQUIRED).**

FOR TREATMENT: I may use your protected health information to provide treatment or services to you. I may disclose your protected health information to other doctors who are involved in taking care of you. Generally, you will sign an authorization to release your records.

FOR PAYMENT: I may use and disclose medical information about your treatment and services to bill and collect payments from you, your insurance company, health plan, or another third party payer. For example, I may need to give your insurance company information about your

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treatment so they will pay me or reimburse you for the treatment. I may also inform your insurance company about the treatment you are going to receive to determine whether your plan will cover it.

FOR HEALTHCARE OPERATIONS: I will also use your protected health information to assist in running my operations.

I may also use and disclose your protected health information to my business associates whom I contract with to perform services or to remind you that you have an appointment for medical care.

TO BUSINESS ASSOCIATES: Some services are provided to me or on my behalf through contracts with third parties ("business associates"). For example, I may disclose your protected health information to a copy service I use when making copies of your health record. When these services are contracted, I may disclose your protected health information to my business associates so they can perform the duties I have asked them to do and bill you or your third party payer for the services rendered. To protect your protected health information, however, I require my business associates to appropriately safeguard your information.

TO INDIVIDUALS INVOLVED IN YOUR CARE OR YOUR PAYMENT FOR YOUR CARE: I may, in my professional judgment, use or disclose your protected health information to a family member, other relative, a friend, or any other person identified by you who is involved in your medical care or who helps pay for your care (including your health insurance company). In an emergency situation or in the event of your incapacity, I may exercise my professional judgment to determine whether a disclosure to a particular person is in your best interest. I will disclose only the information that I believe is directly relevant to the persons involved in your health care or payment for your care.

AS REQUIRED OR PERMITTED BY THE LAW: I will disclose protected health information, if I am required or permitted by law to do so, including the following:

PUBLIC HEALTH ACTIVITIES: I may disclose protected health information for authorized public health activities: To public health officials, to prevent or control disease, injury or disability; to the US Food and Drug Administration (the FDA), as required or permitted by the FDA; to report to employer, as required under law as addressing work related illnesses and injuries or work place medical surveillance.

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VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: If I reasonably believe that you are a victim of abuse, neglect or domestic violence, I may disclose your protected health information to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

FOR HEALTH OVERSIGHT ACTIVITIES: I may disclose your protected health information to a health oversight agency that oversees the healthcare system and is charged with the responsibility for insuring compliance with the rules of government health programs such as Medicare or Medicaid.

TO LAW ENFORCEMENT OFFICIALS: I may disclose your protected health information to the police or other law enforcement officials in certain limited, allowable circumstances or in compliance with a court order or grand jury or an administrative subpoena.

LEGAL PROCEEDINGS: I may disclose your protected health information in the course of a judicial administrative proceeding in response to: (1) A court order; (2) A legally valid order issued by a state or federal administrative agency or licensing board; (3) A subpoena, discovery request or other lawful process in a third party action, but only after efforts have been made to notify you that your protected health information has been sought, so that you can obtain an order protecting the information requested.

2. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

USES AND DISCLOSURES OF YOUR HIGHLY CONFIDENTIAL INFORMATION: Federal and State laws require special privacy protections for certain highly sensitive information about you. ("highly confidential information"), including the subset of your protected health information that: (1) Is maintained in psychotherapy notes; (2) Is about mental health and developmental disability services; (3) Is about alcohol and drug abuse prevention, treatment, and referral; (4) Is about child abuse and neglect; (5) Is about domestic abuse of an adult with a disability or (6) Is about sexual assault.

For purposes other than those permitted or required by law, I must obtain your written authorization in order for me to disclose your highly confidential information.

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HOW YOU CAN ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION: The following describes the action you may take with respect to your protected health information that I maintain.

INSPECT AND COPY: You may request to inspect and obtain a copy of your protected health information that may be used to make decisions about you and your treatment so long as I maintain this information in my records. Usually, this includes medical and billing records. Under Federal Law, however, you may not inspect or copy the following: (1) Psychotherapy notes; (2) Information compiled in reasonable anticipation of, or use in legal proceedings; or (3) Information subject to a Federal Law that prohibits access to protected health information. I may deny your request to inspect and copy in certain very limited circumstances. If you were denied access to your protected health information, you may request that the denial be reviewed in some situations. I will comply with the outcome of the review.

If you request a copy of your protected health information, I may charge a fee for the cost of copying, mailing or other supplies I use to facilitate your request. If you wish to make a request, you may obtain a request form or submit your detailed request in writing, including the protected health information you are requesting access to and the relevant dates.

AMENDMENT: If you feel that your protected health information is incorrect or incomplete, you may ask me to amend the information, so long as the information is kept by me, or for my records. I may deny your request for amendment and if this occurs, you will be notified of the reason for denial. If you wish to make a request, you may obtain a request form, or submit your detailed request in writing to me. You must include your reasons for the request.

ACCOUNTING OF DISCLOSURES: You may request an accounting of disclosures. This is a list of certain disclosures I have made of your protected health information for purposes other than treatment, payment or health care operations during any time, prior to the date of your request provided: (1) Such period does not exceed six years; (2) Disclosures made for treatment, payment, health care operations and certain other limited purposes will not be included; (3) Disclosures that occurred prior to October 1st, 2003 are also excluded. If you wish to make a request, you may also obtain a request form or submit your detailed request in writing to me.

For accounting, I may charge you for the cost of providing the accounting. I will notify you of the cost involved in advance; you may choose to withdraw your request at that time before any cost is incurred.

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REQUEST ADDITIONAL RESTRICTIONS: You may request restriction of limitation on my use or disclosure of your protected health information for purposes of treatment, payment or health care operations. You may also request a limit on your protected health information I disclose to someone who is involved in your care or the payment for your care, like a family member, a friend. I am not required to agree to your request. I do agree I will comply with your request unless the information is needed to provide you with emergency treatment. If you wish to make a request, you may obtain a request form or submit your detailed request in writing to me.

REQUEST CONFIDENTIAL COMMUNICATIONS: You may request that I communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that I contact you at work or by US Mail. I will accommodate reasonable requests for confidential communications at alternative locations and/or via alternative means, only if the request is submitted in writing to me and the written request includes a mailing address where you will receive bills for services rendered by myself and related correspondences regarding payment for services. Please realize that I reserve the right to contact you by other means and other locations if you fail to respond to any of the communication from me that requires a response. I will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A PAPER COPY OF THIS NOTICE: You may obtain a paper copy of this notice. You may request a copy of this notice at any time.

CHANGES TO THIS NOTICE: I reserve the right to change this notice and the revised notice will be effective for the information I already have about you, as well as any information that I receive in the future. The revised notice will be effective for all protected health information that I maintain, as of the effective date of such revised notice, even if I collected or received the protected health information prior to the revised notice's effective date. The current notice in effect will be available at my office.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint by contacting the Secretary of the US Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF PROTECTED HEALTH INFORMATION: Other uses and disclosure of the protected health information not covered by this notice or the laws that apply to me will be made only with your written authorization. If you authorize me to use or disclose your

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protected health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose your protected health information for the reasons covered by your written authorization. You understand that I am unable to take back any uses or disclosures that I have already made and reliance on the authorization, and that I am required to retain my records of the care that I have provided you.

Many States have requirements for reporting, including population-based activities relating to improving health care, reducing health care costs. Some States have separate privacy laws that may apply additional legal requirements. If the State law is more stringent than the Federal law, the State law will preempt the Federal law.

3. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

By signing this, I acknowledge that I have received a notice of the privacy practices from Dr. Kimberly Bell.

SIGNATURE: _____

NAME: _____

DATE: _____