PRIVACY POLICY

PRIVACY NOTICE – NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

1. The Practice may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Practice to use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the practice may need to provide the Medicare program with information

about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

NO CONSENT REQUIRED

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations – (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of

coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.
(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(o) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.
(p) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
(q) National Security and Intelligence Activities – The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.
(r) Military and Veterans – If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.
(s) Risk Adjustment Activities under the Affordable Care Act (ACA) – The Practice may disclose your PHI to an insurance company, health plan or their designated Business Associates, in response to the insurance company's or health plan's request for medical records to assess and report risk scores to the Department of Health and Human Services.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: (a) a

email to the email address provided on file; and (b) telephoning your number provided on file and leaving a message on your answering machine or with the individual answering the phone, (c) a text message notification to the phone number provided on file.

DIGITAL COMUNICATIONS

The practice may communicate with you through phone calls, emails and text messages. Due to modern means of communication not being fully secure, please beware of the risks of sharing sensitive information through these means of communication. If you would prefer not to communicate through digital mean, please notify the office.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or

disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:
    (a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
    (b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
    (c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
    (d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer Jim Nugent or Jennifer Strang at 708.488.0900 or via

email at DrNugent@riverForestHealth.com or DrStrang@RiverForestHealth.com.

PRACTICE'S REQUIREMENTS

1. The Practice:
   (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
   (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes: Illinois
   (c) Is required to abide by the terms of this Privacy Notice.
   (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
   (e) Will distribute any revised Privacy Notice to you prior to implementation.
   (f) Will not retaliate against you for filing a complaint.
   (g) Following a breach of unsecured private health information, is required to provide notification to affected individuals, the Secretary of the U.S. Department of Health & Human Services, and, in certain circumstances, to the media. In addition, our business associates must notify our office if a breach occurs at or by the business associate.

With the digital signature noted on this document, I agree to the above terms

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my current insurance company, or if self pay, myself, to pay by check made out to River Forest Health and Wellness, credit card or another approved form of money transfer, for the professional or medical expense benefits allowed and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges over and above this insurance payment.

1: A photocopy of this assignment shall be considered as effective and valid as the original;

2: I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case;

3: I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

FINANCIAL

NOTICE OF NON-COVERAGE OR POSSIBLE NON-COVERAGE UNDER PRIVATE INSURANCE OR HEALTH PLAN

NOTE: If your private insurance carrier or health plan doesn't pay for services rendered, you are responsible and you agree to pay. Your private insurance carrier or health plan does not pay for everything, even some care that you and/or your health care provider have good reason to think you need. Your carrier or plan does not pay for care that it determines to be "medically unnecessary" or

"experimental and/or investigational," even if you and your health care provider deem the care to be necessary or beneficial and its effectiveness substantiated.

To the best of our information at this time (including information that may have been provided by your insurance carrier or health plan, if applicable), we expect and believe your private insurance carrier or health plan may not pay for the

- **Acupunture**
- **Dry Needling**
- **Nutritional Consults including lab analysis**
- **Massage Therapy**

In addition to the procedures listed above, we may perform other procedures that we believe are covered by your insurance carrier or health plan, to the best of our information at this time (including information that may have been provided by your insurance carrier or health plan). Prior to the rendering of services, our office staff has shared with you to the best of our ability the information provided by your carrier or plan regarding coverage for these procedures.

HOWEVER, please be aware of the following:

1) Insurance carriers and health plans do not guarantee that they will pay for services even when they have verified coverage prior to the rendering of services. There are some situations in which a plan representative verifies coverage for a service but the company later refuses coverage.
2) Insurance carriers and health plans sometimes provide coverage for a particular service during a period of medical improvement, but at a point at which the carrier or plan determines medical improvement has ceased, the carrier or plan can determine the exact same services to be non-covered. This is often referred to as non-covered "maintenance care." Our office will exercise its best professional judgment by following substantiated treatment protocols. However, health care providers and insurance carriers

and plans do not always agree about the exact point at which improvement is maximized for a patient. Therefore, you are aware that your insurance carrier or plan may cover certain services initially, but during the course of treatment may deem the same services to be non-covered. You agree to pay for all such services if your carrier or plan determines them to be non-covered.

3) Insurance carriers and health plans have the right to conduct patient records audits of doctors in their network. These audits often occur after treatment has concluded and/or the carrier or plan has paid the doctor. Following an audit, the insurance carrier or health plan in some cases may determine it should not have paid for certain services because the carrier or plan determines them to be non-covered. In these cases the carrier or plan may demand a refund from the doctor after the carrier or plan has paid the doctor. Please be advised that this office has made every effort to determine and share coverage information with you and to notify you when we in good faith believe a service or services will be non-covered. However, we cannot anticipate every action your carrier or plan may take in the future regarding a post-payment determination of non-coverage. Therefore, you are aware you're your carrier or plan may pay for certain services but may conduct a post-payment audit and demand a refund from this office. You agree to pay for all such services if your carrier or plan determines them to be non-covered.

In light of the above possible reasons for non-coverage for any and all services, we are providing you with the attached fee schedule for services that may or may not be covered by your carrier or health plan, so that you are fully apprised as to all potential out-of-pocket costs. Although we have made our best effort to identify the procedures we believe to be non-covered based on information your insurance carrier or health plan has given us, your carrier or plan may ultimately make a different determination as to coverage. You understand and agree to assume all financial responsibility for

payment, regardless of your carrier's or plan's ultimate coverage decision for any specific procedure.

The date or dates of the procedure is the day that services have been rendered

The expected approximate cost of the procedure as as follows

Acupuncture - initial appointment - $145 -$175, Follow up appointment $60-$80
Massage Therapy - $50-$150
Dry Needling - $15-50
Nutritional Consult or lab analysis - $150-350

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- **Choose an option below about whether to receive the procedure listed above, and note that Option 1 is the default option and if options 2 or 3 are desired, I will notify River Forest Health and Wellness Prior to receiving any services.**

___X___Option 1. I want the procedure(s) listed above. You (health care provider) may ask to be paid now, but I also want my private insurance carrier or health plan to be billed for an official decision on payment, which is sent to me on an explanation of benefits. I understand that if my private insurance carrier or health plan does not pay, I am responsible for payment, but I can appeal to my private insurance carrier or health plan by following the directions on the explanation of benefits. If the insurance company does pay, you (health care provider) will refund any payments I made to you, less co-pays, coinsurance or deductibles.

_____Option 2. I want the procedure listed above, but do not bill my private insurance carrier or health plan. You (health care provider) may

ask to be paid now, because I am responsible for payment. I cannot appeal if my private insurance carrier or health plan is not billed.

_____Option 3. I do not want the procedure listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if my private insurance carrier or health plan would pay.

Signing below means that I have received and understand this notice **prior to the services being rendered**. I also intend for this document to serve as a binding agreement between me and my health care provider that supersedes any document or policy to the contrary, in consideration of my health care provider's agreement to provide care. My health care provider will receive and retain a copy of this Notice.

No Call No Show / Same Day Cancelation

For Chiropractic, Physiotherapy or acupuncture services, I understand that there will be a fee of $150 for the initial visit and $75 for any follow up visits applied to any appointment canceled within 24 hours or if I do not call or do not show for my scheduled appointment. For massage therapy services the full amount of the duration of massage will be charged. the I understand that I (or a third party representing me) need to notify River Forest Health and Wellness within 24 hours of a no call no show appointment if there was an emergency in order for the fee to be withdrawn. I understand that emergency status desecration is determined by the physicians of River Forest Health and Wellness.

RIVER FOREST HEALTH AND WELLNESS HIPPA POLICY: I also certify that I have been given the opportunity to read River Forest Health and Wellness's HIPPA policy. I realize that at any time I can request a copy of the HIPPA policy and may ask for clarification. At this time I feel I have a full understanding of the policy.

By signing this form acknowledges that I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.