NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by Premier Integrative Wellness, LLC, a.k.a. Premier Wellness Center and Aglow Med Spa.

We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you the notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

- We may disclose medical information about you in one or more of the following ways:
    - To doctors, nurses, or other personnel involved in taking care of you; to people outside the medical group, such as family members, specialists, or others who are in providing services that are part of your care.
    - For operations, which may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care.
    - To contact you as a reminder that you have an appointment for treatment or care.
    - To tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events, and activities that may be of interest to you.
    - To other healthcare providers in the event you need emergency care.
    - As required by federal, state, or local law.
    - To a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
    - In special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities.
- Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- You have the right to do any of the following:
    - To review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records. Yu must submit a written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.
    - To ask us to amend medical information that you may feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request. We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete.
    - To request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to you. You must submit a written request. The request must state a time period that may be no longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective.
    - To request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request for restriction that specifies: 1) what information you want to limit; 2) whether you

want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it is in conflict with providing you quality healthcare or in an emergency situation.

- To request that we communicate with you about medical matters in a certain way or at a certain location, such as at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.
- To possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice at our clinic.
- To file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. No personal issue will be raised for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We will have available a copy of the current notice at our clinic.

ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices provides information about how we may use and disclose your protected health information. If you would like a copy of the current Notice, please ask a provider or staff member at our office.

I, _____, acknowledge that I have read the Notice of Privacy Practices and understand that I may request a copy of this Notice.

_____ _____

Signature of Patient (or Patient's Representative) **Date**

_____ _____

Printed Name of Patient (or Patient's Representative) **Relationship to Patient**

Written Acknowledgement Not Obtained (to be completed by staff member)

Please document your efforts to obtain acknowledgement and reason it was not obtained:

_____ Notice given – Patient is unable to sign

_____ Notice given – Patient declined to sign

_____ Notice mailed to Patient

_____ Other reason Patient did not sign _____

_____ _____

Signature of Representative Date