

General Consent for Treatment Patients' Rights and Responsibilities Office Policies

A. Consent for Treatment:

I, the responsible party, consent to treatment by Kiings Neurological Care, PLLC, including medical and neurological patient history and examination, and developing a mutually agreeable treatment plan.

B. Authorization for Release of Medical Information:

I consent and authorize Kiings Neurological Care, PLLC, to release my medical and health information, including copies of my medical record, to my insurance company, primary physician and third party administrators (which may pay for part of my medical expenses). Reports are submitted to Managed care agencies summarizing the diagnosis and treatment plan for the patient. In select circumstances, records may be released without patient consent, when dictated by appropriate Federal and State Laws. (See Privacy Form)

C. Patients have the right to:

- Be treated with dignity and respect.
- Fair treatment: regardless of their race, religion, gender, ethnicity, age, disability or type of payment.
- A confidential treatment plan (unless required by law, treatment plan may not be released without member permission).
- Access to timely care.
- Explanation of treatment options.
- Share in developing treatment plan.
- A clear explanation of their condition and treatment options
- Information about clinical guidelines used in providing and managing care
- Ask providers about work history and training
- Know about support and community groups and prevention services
- Have access to health information
- To remove your Consent to Release Information
- Discuss any concerns or complaints with office staff

D. Statement of Patients' Responsibilities:

- Disclose to providers pertinent legal, social and medical information that he/she will need to provide the most complete care.
- Ask questions about your care
- Follow the treatment plan
- Follow the agreed upon medication plan
- Tell your providers and primary care physicians about medication changes, including medications given to you by others
- Let providers know when your treatment plan is not working.
- Let the office know about any problems in paying fees.
- Openly report concerns about the quality of care you receive.
- Maintain scheduled appointments.
- Keep us informed of changes to your personal contact or insurance information.

- Keep us informed about changes in your medications, adverse effects to medications, use of over-the-counter, herbal or alternative treatments, use of alcohol or other substances of abuse, or changes in your medical health.

E. General Billing Policies:

- **Payment, including deductibles and co-pays, is required at the time of service.**
- Patient is responsible for any payments and charges for services not covered or not authorized by your insurance plan.
- Although Kiings Neurological Care, PLLC, will make every attempt to verify benefits and to determine liability, it is the responsibility of the patient to make payment of any rejected services.
- The patient will remain responsible for services provided, should either party terminate the healthcare relationship.

F. Policies and Practices to Protect the Privacy of your Health Information

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. 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

This notice was revised and becomes effective on September 23, 2013.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills and to support the operation of the physician's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. Please see below regarding your right to request a restriction of your protected health information.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality

Kiings Neurological Care, PLLC

445 Dallen Madison Road, Suite 210, Greensboro, NC 27410 Phone: 336.265.1001 Fax: 336.265.1000

assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and, if you are unavailable, we may leave the information with another member of your household or on your voice mail.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever such an arrangement involves the use or disclosure of your protected health information, we will have a written contract that will protect the privacy of your protected health information. All business associates are directly subject to certain provisions of the HIPAA Privacy Rule and all provisions of the HIPAA Security Rule, and must, therefore, comply with such legal requirements and with their contractual obligations with us.

We may use or disclose your protected health information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, including most uses and disclosure of psychotherapy notes, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability.

Other uses and disclosures of your protected health information will be made only with your written authorization, including most uses and disclosure of psychotherapy notes, unless otherwise permitted or required by law as described below. You may revoke this authorization,

at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. Please see below regarding your right to request a restriction of your protected health information. **Uses and Disclosures of Protected Health Information With Your Written Authorization**

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child or elderly abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Your Rights

All requests to exercise your rights as outlined must be in writing and delivered to our office.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to obtain a copy of your protected health information in electronic format if such information is contained in an electronic health record. This means you may obtain a copy of your protected health information in electronic format, or have such electronic copy sent to an entity or person designated by you, if we maintain such information in an electronic health record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Except in the case of a requested restriction on disclosure to a health plan for payment or health care operations purposes when the protected health information relates solely to an item or services for which you have paid-in-full out of pocket, your physician is not required to agree to a restriction that you may request.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to request that your physician amend your protected health information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to all disclosures made through the use of electronic medical records and all other disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. Accountings of disclosures made through the use of electronic health records may only be requested for a period not to exceed three years prior to the date of such request.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to receive notification in the event of a breach of unsecured protected health information.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Privacy Contact

You may reach our privacy contact at: 336.365.1001
Or by mail or in person at 445 Dolley Madison Road Suite 210
Greensboro, NC 27410

This notice describes how neurological and medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

Kiings Neurological Care, PLLC, may use or disclose your protected health information (henceforth termed PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- A. "PHI" refers to information in your health record that could identify you.
- B. "Treatment, Payment and Health Care Operations" refers to the following:
 - 1. Treatment is when Kiings Neurological Care, PLLC, provides, coordinates or manages your health care and other services related to it. An example would be when we consult with another health care provider, such as your family Physician, Internist or your Psychiatrist/Psychologist.
 - 2. Payment is when we obtain reimbursement for your care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - 3. Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business related matters, such as audits and administrative services, and case management and care coordination.
- C. "Use" applies only to activities within our office such as employing, applying, utilizing, examining and analyzing information that identifies you.
- D. "Disclosure" applies to activities outside our office; such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of your treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. If a provider at Kiings Neurological Care, PLLC, keeps separate "neurological notes" we will also need to obtain an authorization before releasing the information contained in these notes. "Neurological Notes" are notes that some providers have made about your treatment during our

Kiings Neurological Care, PLLC

445 Dolley Madison Road, Suite 210, Greensboro, NC 27410 Phone: 336.365.1001 Fax: 336.897.1533

sessions. These notes will be kept separate from the rest of your medical records and are given a greater degree of protection than your PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) We have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Possible Use or Disclosure of PHI or Psychotherapy Notes without Consent or Authorization

Kiings Neurological Care, PLLC, may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Abuse: If we have reasonable cause to believe that a child has been abused, we must report this to the appropriate authority.
2. Adult and domestic abuse: if we have reasonable cause to believe that a disabled adult or elder person has had physical injury or other types of injuries inflicted on them, other than by accidental means, or has been neglected or exploited, we must report this to the appropriate authority.
3. Health Oversight Activities: if we are subject of an inquiry by the Composite State Board of Medical Examiners or Federal Government regulatory agency or Court of Law, with appropriate authority, we may be required to disclose your PHI or psychotherapy records.
4. Judicial and Administrative Proceedings: if you are involved in court proceeding and a request is made about the professional services provided to you, we may provide relevant information regarding the dates and times of service. We may also provide other relevant PHI; however, other information, or any information that is privileged under state law, will not be released without your consent or court order. Please be advised that the privilege does not apply when you undergo an evaluation for a third party or when the evaluation is court-ordered; in these instances, you will be informed as to whether your records are privileged or not.
5. Serious Threat to Health and Safety: if we determine, or pursuant to the standards of psychiatry and or neurology should determine, that you present a serious danger of violence to yourself or another person, we may disclose information in order to provide protection against such danger for you or the intended victim.
6. Workers' Compensation: we may disclose PHI to the extent necessary for work related injuries or illness without regard to fault.

IV Patients' Rights and Psychiatrist's Duties Patients' Rights

1. Right to Request Restrictions: you have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction request.
2. Right to receive Confidential Communication by Alternative Means and at Alternative Locations: you have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are a patient of Kiings Neurological Care, PLLC; on your request, we will send the bill to another location.)
3. Right to Inspect and Copy: you have the right to inspect or obtain a copy (or both) of PHI used to make decisions about you for as long as the PHI is maintained in the record, subject to fees for copying. We may deny access to you PHI under certain circumstances, but in some cases, you may have the decision reviewed. On your request, we will discuss with you the details of the request and denial process.
4. Right to Amend: you have the right to request an amendment of PHI as long a PHI is maintained in the record. We have the right to deny your request. On your request, we will discuss with you the details of the amendment process.

Neurologist's Duties

1. We are required by law to maintain the privacy of PHI and to provide you with a Notice of my legal duties and privacy practices with respect to PHI.
2. We reserve the right to change privacy policies and practices with respect to PHI.
3. If we revise the policies and procedures we will provide you with a revised notice via our message board at the front desk.

Office Policy

We strive to provide the best care for our patients. In order to do so, we need to make sure all our patients are aware of these policies. Please review them carefully and sign at the bottom. We thank you for your understanding and cooperation.

1. **Prescription refills:** You will be given an adequate amount of medication(s) at each visit, until the physician's requested follow-up appointment.
2. **Forms/Letters:** If you have forms or letters that need to be completed outside of your appointment please allow 2-3 business days for completion. **DISABILITY FORMS WILL BE ADDRESSED AFTER THE PATIENT HAS BEEN SEEN A MINIMUM OF THREE TIMES.** Completion of such documents remains at the discretion of the physician/provider.
3. **The Following May Lead to Termination from Treatment:**
 - Repeated failure to keep an appointment without notice.
 - Failure to pay for services rendered.
 - Failure to follow mutually agreed treatment plan.
 - Refusal to comply or tampering with pharmacological screening in any form.
 - Unruly, rude, or aggressive behavior or speech to any provider or employee of the practice.

By signing below, you acknowledge the above policies, that you consent to be treated, and that you have received a copy of our "Patient's Rights and Responsibilities".

Date _____

Signature of Patient/Parent/Guardian/Authorized Representative