Balanced Healing Acupuncture
1340 Corporate Dr Suite 100
Hudson Ohio 44236
330-203-0535

Practice Guidelines and Financial Policy

Information: You agree to provide your correct name, current address, phone numbers, and email address at the time of the initial appointment.

Appointments: We require 24 hours' notice if you are unable to make your scheduled appointment. The full amount for the missed session will be charged to you in the event of failing to show for your appointment or not giving sufficient notice.

Payment Methods: Payment is due at the time of the appointment. We accept cash checks, and major credit cards.

Medical Records: The medical chart is the property of the practice. However, a copy of your pertinent medical information is available upon your request. A fee will be charged for copying multiple pages in accordance with Ohio Law.

Patient Discharge: The practice reserves the right to discharge a patient for any reason despite goals not being met. Please note that an early discharge may occur for failure to meet your obligations under this document. In addition, due to quality of care considerations, the practice may discharge you for failure to comply with the treatment plan as outlined by your practitioner.

Financial Responsibility: By signing below, you accept financial responsibility for all charges and services rendered to you. If the patient is a minor or under guardianship, the parent or guardian accompanying the patient assumes responsibility.

By signing below, I acknowledge receipt of this policy and agree to the terms.

_____	_____	_____
Print Name	**Signature**	**Date**

Balanced Healing Acupuncture
Notice of Privacy Practices

5/1/12

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. If you have any questions about this notice, please contact the Privacy Officer of this practice.

WHO WILL FOLLOW THIS NOTICE
This notice describes the personal health information (hereafter referred to as PHI) privacy practices followed by our employees, staff, and other personnel.

YOUR HEALTH INFORMATION
This notice applies to the information and records we have about your health, health status, mental health care, mental health status, alcohol and other drug treatment, and services you receive from our employees.

We are required by law to give you this notice describing your rights and our obligations regarding the use of that information.

HOW WE MY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: We may use PHI about you to provide you with treatment or services. A staff member may obtain PHI about you and create a record of this information, which may then be used to determine the course of treatment that should work best for you. A staff member may call you to remind you of an appointment.

For Payment: We may use and disclose PHI about you so that the treatment and service you receive at this office may be billed to and payment may be collected from you.

For Health Care Operations: We may use and disclose PHI about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your PHI to evaluate the performance of our staff in caring for you. We may also use PHI about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

OTHER USES AND DISCLOSURE OF HEALTH INFORMATION
We may use or disclose PHI about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose PHI about you when required to do so by federal, state, or local law.

Public Health Risks: We may disclose PHI about you for public health reasons toreport suspected abuse or neglect of minors.

Information Not Personally Identifiable: We may use or disclose PHI about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose PHI about you to your family members or friends if we obtain your written agreement to do so, or if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your PHI to your spouse when you bring your spouse with you into a treatment room while the treatment is discussed.

For Workers' Compensation: We may share your PHI with W. C. agencies if needed for a benefit determination.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION
We will not use or disclose your PHI for any purpose other than those identified in the previous sections without your specific, written authorization. You may revoke that authorization in writing at any time, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Right to Inspect and Copy: You have the right to inspect and copy your PHI, such as treatment records. You must submit a written request to the Privacy Officer in order to inspect and/or copy your PHI. If you request a copy, we may charge a fee for the costs of copying, mailing, or other associated supplies.

Right to Amend: If you believe health information we have about you is incorrect, you ay ask us to amend the information. To request an amendment, submit a letter stating what information in your medical record you would like amended to the Privacy Officer. We may deny your request for an 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 you ask us to amend information that: a) we did not create.

b) is not part of the PHI that we keep.
c) you would not be permitted to inspect and copy.
d) is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures," a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations. Submit this request to the Privacy Officer. It must state a time period not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (e.g. on paper, electronically). We may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (e.g. at work or by mail). To request confidential communication submit a letter stating your request to restrict the use/disclosure of medical/mental health information and /or confidential information to the Privacy Officer. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You Have the Right to a Paper Copy of This Notice: You may ask for a copy of this at any time.

CHANGES TO THIS NOTICE

We are required to abide by the terms of this notice. However, we reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Balanced Healing Acupuncture,LLC, 9046 Skylane Dr, Wadsworth, OH 44281.

My signature below indicates that I have been provided with a copy of Balanced Healing Acupuncture, LLC's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to patient_____