Neuropsychological & Clinical Psychotherapeutic Services, LLC

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. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Neuropsychological & Clinical Psychotherapeutic Services, LLC (NeuroPsychCPS) and all business associates with whom we may share your protected health and medical information. We provide the Notice of Privacy Practices to every patient who whom we have a direct assessment/treatment relationship. Every effort will be made to obtain a signed Receipt of Notice of Privacy Practices from each patient that will be kept on file. If the patient refuses to sign the form, it will be noted that the Notice was given but the patient to or could not sign the receipt.

We understand that your protected health information is confidential and we are committed to maintaining its privacy. Federal law requires that we provide you with this Notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this Notice when we use or disclose your protected health information.

HOW WE MAY USE AND DISCLOSE MEDICL INFORMATION ABOUT YOU
We may use and disclose protected health information about you without your prior authorization for the following reasons:

Treatment Purpose. For example, to diagnose and treat your illness, activities related to providing services to the patient. In addition, we may contact you to provide appointment reminders. We may also disclose your protected health information to other providers involved in your treatment.

Payment Purposes. Such as the submission of claims and sending billing information to your health insurer, or other company or program that will pay for your health care and any additional information requested by the insurance company so they can determine if they should claim.

Health Care Operations. For example, we may also disclose protected health information to other health care providers when such protected health information is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, and peer review.

Disclosure to Family, Close Friends and Other Caregivers. In an emergency situation, we may disclose protected health information about you to those involved in a patient's care when the patient approves or, when the patient is not present or not able to approve, when such disclosure is deemed appropriate in the professional judgement of the practice. When the patient is not present, we determine whether the law requires the disclosure of the patient's protected health information and if so, disclose only the information directly relevant to the person's involvement with the patient's health care. We do not disclose protected health information to a suspected abuser, if it's professional judgement, there is reason to believe that such a disclosure could cause the patient serious harm. Further, we use and disclose information as required by law.

Other Disclosures Required by Law. We may also use or disclose protected health information about you without your authorization, subject to certain requirements and **as required by law**, for several other reasons to include: **public health activities** for the purpose of preventing or controlling disease; **abuse and neglect,** to a governmental authority if we reasonable believe you are a victim of abuse, neglect or domestic violence or to avert a serious threat to health or safety**; health oversight activities or inspections,** to a health oversight agency that oversees the health care system; **judicial, administrative and law enforcement purposes** in response to a subpoena or a request by a law enforcement officer, workers' **compensation purposes** and your **health and safety.** We may also disclose your protected health information as appropriate to provide treatment in emergency situations. In those instances where we have not previously provided our Notice of Privacy Practice to a patient who receives direct treatment in an emergency situation, we provide the Notice as soon as practicable following the provision of emergency treatment.

We may contact individuals through telephone and main with appointment reminders and may utilize facsimile transmissions for specific authorizations and prescriptions refills through pharmacies.

USE AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION
For any purpose other than the ones described above, we will only use or disclose your protected health information when you give us your written authorization. For instance, we will obtain your written authorization before we can send your protected

health information to your employer or health plan sponsor, for underwriting and related purpose or Life Insurance Company or to the attorney representing the other party in litigation in which you are involved.

Highly Confidential Information. Federal and state law requires special privacy protections for highly confidential information about you. Highly Confidential Information consists of protected health information related to: psychotherapy notes; mental health and developmental disabilities services; alcohol and drug abuse services; HIV/AIDS testing, diagnosis or treatment, venereal disease(s); genetic testing; child abuse and neglect; domestic abuse of an adult with a disability; or sexually assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

For further Information or Complaints. If you have questions or are concerned that your privacy rights have been violated or disagree with a decision that we made about access to your protected health information, you may contact our Privacy Officer/Practice Manager who serves as the contact person for all issues related to the Privacy Rule. Written complaints may also be filed with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing, must name the practice, must describe the acts or omissions that are the subject of the complaint, and must be filed within 18 days of the time you became aware of should have become aware of the violation. Complaints must be addressed to NeuroPsychCPS at our address and to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, DW, Washington, DC 20201. We will not retaliate or take any adverse action against you if you filed a complaint.

Right to Inspect and Copy Your Protected Health Information. You have a right to inspect or get a copy of your medical record file and billing records maintained by us. Under some circumstances, we may deny you access to a portion of your records. If you desire access to your records, please submit your request in writing to NeuroPsychCPS. A reasonable fee not to exceed limits allowed under state law will be charged for the copying, mailing other related supplies.

Right to Amend Your Record. You have the right to request that we amend protected health information maintained in your medical record file or billing records. If you desire to amend your records, please submit your request in writing to NeuroPsychCPS. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply. In the case of a request amendment concerning information about the treatment of a mental illness or developmental disability, you have the right to appeal our decision not to amend your protected health information.

Right to Receive Confidential Communications. We accommodate all reasonable requests to keep communications confidential and to allow you to receive your protected health information by alternative means of communication or at alternate e locations. A request for confidential communications must be in writing, must specify an alternative address or other method of contact and must provide information about how payment will be handled. The request should be submitted to the NeuroPsychCPS. We will determine the reasonableness based on the administrative difficulty of completing with the request. We will reject a request due to administrative difficulty if no independently verifiable method of communication such as a mailing address or published telephone number is provided for communications; or if the requestor has not provided information as to how payment will be handled.

Right to Restriction of Disclosures. You may submit a request in writing to NeuroPsychCPS that we not use or disclose protected health information about you for treatment, payment or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider all requests for additional restrictions carefully, however we generally do not agree to any restrictions. NeuroPsychCPS will notify the requestor in writing if we do not accept the requested restrictions of disclosure.

Authorization. We obtain written authorization from a patient or a patient's representative for the use or disclosure of protected health information for reasons other than treatment, payment or health care operations. We will not, however get an authorization for the use or disclosure of protected health information specifically allowed under the Privacy Rule in the absence of an authorization. We will provide patients with a copy of any authorization initiated by us and signed by the patient upon request at the time of signing the authorization.

We do not condition treatment of a patient on the signing of an authorization, except disclosure necessary to determine payment of claim (excluding authorization for use or disclosure of psychotherapy notes); or provision of health care solely for the purpose of creating protected health information for disclosure to a third party (pre-employment or life insurance exams).

A specific written authorization is required to disclose or release mental health treatment notes, alcoholism treatment, drug abuse treatment or HIV / Acquired Immune Deficiency Syndrome (AIDS) information.

Right to Revoke Your Authorization. You have the right to revoke your written authorization obtained in connection with the release of your protected health information or mental health information, except to the extent that we have taken action in reliance upon it, by submitting your request in writing to NeuroPsychCPS.

Effective Date and Changes to this Notice. This Notice is effective April 01, 2016. We reserve the right to restive this Notice at any time. If we change this Notice, we may make the new notice terms effective for all protected health information that we maintain, including any information that we maintain. If we change this Notice, the new Notice will be posted in the waiting room of the NeuroPsychCPS. You may also obtain any new Notice by contacting NeuroPsychCPS.