



NOTICE OF PATIENT INDIVIDUAL RIGHTS

8750 Wilshire Blvd, Suite 350, Beverly Hills, CA 90211

Pursuant to the health Insurance Portability and Accountability Act (“HIPAA”), this notice to you that with respect to your medical and health care records at this office, you have the following rights:

1. RIGHT TO ACCESS AND COPY INFORMATION.

In Accordance with 45 C.F.R. §164.524, you have the right to access and copy your own protected health information (“PHI”) maintained in “designated record sets”. A designated record set includes your medical records and billing records maintained in this office.

Our office is required to respond to your request for access and/or copying of your records within 30 days following receipt of a written request from you. If your records are not accessible on site in the office, we are required to respond within 60 days.

If for some reason we deny your request to access or copy your records, you may appeal that denial to the contact person/privacy officer at this office, whose name, phone number and address are listed below.

You may be charged a reasonable fee for costs associated with the copying of your records. These costs typically will be ten cents (\$0.10) per page for standard reproduction of documents of a size 8 ½ by 14 inches or less and reasonable clerical costs incurred in locating and making the records available to be billed at the maximum rate of sixteen dollars (\$16.00) per hour per person, computed on the basis of four dollars (\$4.00) per quarter hour or fraction thereof and actual postage charges

2. RIGHT TO AMEND INFORMATION.

In accordance with 45 C.F.R. §164.526, you have the right to amend erroneous or incomplete PHI, unless the information was not created by our office, or the information is not in a “designated record set”, or is accurate and complete, or would not be available for inspection under the previous section.

Our office is required to respond within 60 days, following receipt of a written request from you, by granting or denying your request. If we deny your request, you may file a statement of disagreement which will be included in your records. If you grant your request to amend the records, we will make the correction in all affected records, inform our business associates and others regarding the correction as needed and we will inform you when the correction has been made. Any corrections that may be made will conform to the medical practice model for amending medical records in order to retain the integrity of the original entry but append the correction.

3. RIGHT TO OBTAIN ACCOUNTING OF DISCLOSURES.

In accordance with 45 C.F.R. §164.528, you have the right to obtain an “accounting” of disclosures of your PHI made within six years before the request, starting from the effective date of April 14, 2003.

The accounting shall include disclosures of your PHI made by both our office and our business associates and shall include the date, receipt name and address, description of the information disclosed, and the purpose of the disclosure.

Our office is required to respond within 60 days following a receipt of a written request from you. Disclosures exempt from the accounting requirement include those: (a) to carry out treatment, payment or health care operations; (b) to you or your personal representatives; (c) for incidental purposes such as the office sign-in sheet; (d) to family members and others involved in your care; (e) for national security or intelligence purposes; and (f) correctional institutions and other law enforcement agencies under the custodial exception.

4. RIGHT TO REQUEST RESTRICTION OF USE OR DISCLOSURE.

In accordance with 45 C.F.R. §164.522(a), you have the right to request restrictions on how our office will use or disclose your PHI for treatment, payment, or health care operations and how your information will be disclosed to family members or others involved in your care. Our office is not required to agree to such restriction. However, if we agree, then we are



obligated to comply with that agreement unless the information is required for an emergency, or is requested for law enforcement, judicial and administrative proceedings or research.

5. RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION.

In accordance with §164.522 (b), we will accommodate reasonable request from you to receive communications of your PHI by alternative means or at alternative locations. For example, you may request our office not to send certain medical information to your home, so that a family member cannot access that information.

6. RIGHT TO RECEIVE NOTICE OF PRIVACY PRACTICES.

In accordance with 45 C.F.R. §164.520, you have the right to receive a notice of our office's privacy practices that describe the uses and disclosures of PHI, your rights under the Privacy Standards and our legal duties regarding PHI. We are required to inform you of your right to complain to our office or the Department of Health and Human Services (DHSS) Secretary, if you believe that your privacy rights have been violated. If you have any questions or if you wish to register a complaint, contact the administrator for your provider.

Privacy Officer
8750 Wilshire Blvd. Suite 350
Beverly Hills, CA 90211
Phone: 310-652-0010

The notice referred to in the preceding paragraph will be in plain language. Our office reserves the right to change its privacy practice in its privacy notice, but we will first publish a revised notice prior to any change in practices. Our office will provide its notice to patients upon request, at first service and on our Web Site if a web site is available.

7. RIGHT TO CONSENT TO OR AUTHORIZE CERTAIN USES AND DISCLOSURES.

As discussed in the section on uses and disclosures of PHI, infra, certain uses or disclosures will require your permission, whether consent, authorization or advance notice with an opportunity to object. In each of these circumstances, you have the right to grant or withhold that permission.

8. RIGHT TO COMPLAIN OF PRIVACY VIOLATIONS.

You have the right to complain if your privacy rights have been violated. You may complain to the contact person/privacy officer at this office, whose name, phone number and address are listed below. You may also complain to the DHSS Secretary through the Office of Civil Rights at 1-866-627-7748.

We cannot require that you waive this right as a condition for providing treatment, payment or other services and cannot retaliate against you for lodging a complaint with the Secretary.



NOTICE OF PRIVACY PRACTICES

8750 Wilshire Blvd, Suite 350, Beverly Hills, CA 90211

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), 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.

If you have any questions about this notice, please contact our Privacy Officer at 8750 Wilshire Blvd., Suite 350, Beverly Hills, CA 90211

A. Who Will Follow This Notice

This Notice describes the privacy practices relating to protected health information (“PHI”) followed by the providers at the practice and all of the employees and staff. The doctors, the office employees and staff may share your medical information with each other for treatment, payment of health care operations purposes described in this Notice.

B. Understanding Your Health Record/Information

Each time you visit a physician, hospital or other healthcare provider, a record of your visit is typically made. This record generally contains your symptoms, examinations and test results, diagnosis, treatment and plan for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among the doctors and other healthcare providers that are involved in your care; a medical-legal document describing the care you have received; a means by which you or a third-party can verify that services billed were actually provided; a source of data for medical research, education and data collection; a source of information for public health officials charged with improving community health and other healthcare operations.

C. Our Policy Regarding Medical Information

We understand that medical information about you and your health (“PHI”) is personal. Our commitment to you is to protect medical information about you. Our office creates a record describing the care and services you receive at our office. This record is necessary in order to provide medical care to you and to comply with certain legal requirements. This notice applies to all of the records created in our office in connection with your care and treatment, whether made by the doctor and/or the employees and staff.

We may be sending automated SMS text/email reminders about your upcoming appointments. If this not authorized, please notify us. Please update us with your contact information, including your phone number regularly. We will only be sending you generic reminders, which include:

- Patient first name
- Appointment date and time
- Provider first and last name
- Location of the appointment



PATIENT CONSENT TO NOTICE OF PRIVACY PRACTICES

In Accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have been provided with our Notice of Privacy Practices that provides information about how we may use and disclose protected health information (“PHI”) about you. The notice provides a more complete description of information uses and disclosures.

As part of your healthcare, we maintain health records that describe your health history, symptoms, examinations and test results, diagnosis, treatment and plans for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among other health professionals who contribute to your care; a source of information for applying your diagnosis and healthcare information to bill third parties; a means by which a third-party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the delivery of medical services.

You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice and/or privacy practices may change. If we change our Notice and/or privacy practices, we will provide you with a revised copy by mailing it to your then-current address.

You have the right to object to the use of disclosure of your health information. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial {_____} I request the following restrictions to the use or disclosure of my health information:

I have received and read the Notice of Privacy Practices and Patient Individual Rights and consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described therein.

Signature: _____

Date: _____



ATTUNE HEALTH

Autoimmune and Inflammation Care and Research

Out-of-Network Insurance Policy

This office is in network with Medicare, Blue Cross, and Blue Shield PPO & EPO. If you have any other insurance, you are NOT in network with our office and we are considered an “Out-of-Network Facility,” which means that we are not contracted with your health insurance company. In utilizing our services, please be advised that you may be responsible for an increased co-payment, deductible and co-insurance according to your insurance company’s Explanation of Benefits (EOB).

Medical Billing Process

As a courtesy to you, this office will still submit a medical “claim” to your primary (and secondary) health insurance company for processing. It is important that you give us your most current and/or updated information to the office staff, since your complete and current information is necessary to submit an accurate claim form to your health insurance company.

For out of network insurances, if our real time eligibility system cannot verify if your out-of-network deductible has been met, we will collect FULL payment of \$500 (for new patients) and \$250 (for follow up patients) towards your visit. Please be advised this is not the full amount of services rendered at the time of your visit.

After our billing office receives the EOB from your Insurance Carrier, our office will mail you a statement that contains the total cost of the service(s) and/or procedure(s) you received during your visit. You may expect this bill within 30-45 days after the date you saw the physician. If we receive payment from your health insurance company, it will be deducted from your bill by our billing office and any unpaid balance will be billed to you. If you receive payment directly from your Insurance Carrier, it is your responsibility to forward the entire payment received to our office within 5 days of receiving the payment.

Please acknowledge that you have read, understand, and agree to this policy:

Signature: _____ Date: _____

Print Name: _____



The patient or the responsible party must:

- Inform this office of the current address and phone number for the patient and the responsible party.
- Present all current medical insurance cards prior to each office visit.
- Pay any required copay at the time of the visit, as well as all previous balances due.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When the provider receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).
- **Collections** – The responsible party may be sent to collections after 90 days past due, and interest will be added.
- **Returned Checks** – If a payment is made on an account by check, and the check is returned for any reason, the responsible party will be responsible for the original check amount in addition to a \$35 service charge.

Insurance – This office is only in network with Medicare, Blue Cross and Blue Shield PPO & EPO plans.

- **Out-of-network** - For out-of-network insurances, if our real time eligibility system cannot verify if your out-of-network deductible has been met, we will collect a PARTIAL payment towards your visit. Please be advised this is not the full amount of services rendered at the time of your visit. Please also be advised that you may be responsible for an increased deductible or co-insurance based on your insurance company’s Explanation of Benefits. If you have no Out-of-Network benefits, you will be considered a cash pay patient, and all fees will be due at the time of service.
- **Medi-Cal/HMO** – This office is not contracted with any Medi-Cal, Medicaid and/or any Managed (HMO) plans whether it is in California or any other state. If your only insurance is Medi-cal/HMO, you will be considered a cash patient and all fees will be due at the time of service.

Late Policy – Our office allows a 15 minute grace period from the time you are requested to be in for your appointment. Past the 15 minutes, you may be given the option to wait for another appointment time on the same day if one is available, or you may be asked to reschedule your appointment.

Email Content - All of our patients will receive complementary Attune Health newsletters and related content by email.

I am not interested in receiving Attune Health’s complementary newsletter and/or related content.

No Show Policy – If you are unable to keep an appointment, our office requires at least 24 hour notice. You can cancel/reschedule an appointment by speaking to someone from the office in person or on the phone, or leaving a voicemail message. New patients will be charged \$150 for a no show, follow up visits will be charged \$75 for a no show, and infusion patients will be charged based on the amount of time your infusion generally takes (\$150 per hour).

External prescription history – I authorize the provider I see to view my external prescription history via the MyChart service. I understand that this information may be needed to best assist with my care.

Prescription policy – I understand that my doctor will attempt to refill prescription request within 2 business days (Monday – Friday). Refill request may be done in person at my appointment, via phone or voicemail, via letter to my doctor’s office, or through CS link. I understand I must allow adequate time to ask for refills before I run out of medicine, including enough lead time for us to prepare prescriptions for you to mail to a prescription service.

Narcotics policy - Due to increasing reports of abuse of narcotics, and the subsequent surveillance of the prescription practices of physicians by the state, this office normally will not prescribe continuous pain medication. I understand if I require strong narcotics on a continuous basis, I will be referred back to my Primary Care Physician or a Certified Pain Management Physician.

Prior Authorizations – I understand that some medications I may take will require a prior authorization. The authorization process can take up to 4 weeks and may be longer if the insurance denies and an appeal is needed. If multiple appeals are needed, charges may apply. I understand that a prescription card may be requested from me and may help with the authorization process.

Our doctors and staff truly appreciate your compliance and understanding to these policies so that we can continue to provide excellent medical care.

Print: _____

Signature: _____

Date: _____