

Kenneth C. Greep L.Ac.

NOTICE OF PRIVACY POLICIES

This office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. We will only use and/or disclose your protected health information when the law allows us to do so. Any other use and disclosures will be made only with your authorization and, in those instances; you have the right to revoke that authorization. And if so, that authorization would be honored, where legal to do so, from that date forward.

Treatment: For example, from time to time, your practitioner may decide that it is medically necessary to refer you to a specialist for additional care. That practitioner will need your medical information in order to be able to treat you and that is why we send out your records.

Payment: Many of our patients utilize medical insurance that actually pays for their treatment. The insurers require your medical information to know how to pay us or your care and that is why we send out your records.

Health Care Operations: We are allowed to disclose your medical information if that is necessary for our office to function efficiently. There are also times when we may need the help of a special vendor, such as a medical billing specialist, and we would then send your records to that vendor in order for us to carry on our business.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, holiday cards, thank you cards, newsletters and appointment reminders, by calls, postcards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law. This includes but is not limited to Public Health needs, Health Oversight requirements, and issues of abuse or neglect, legal proceedings.

Patient Rights

• Upon written request you have the right to access, review or receive copies of your healthcare records. Exceptions are: 1) psychotherapy notes; 2) information we gather in preparation of an administrative action or proceeding; 3) data that is subject to certain provisions of the Clinical Laboratory Improvements Act. We may deny you request (in writing) under certain limited circumstances. Generally, if we agree to provide you with a copy of your records, we will do so within 15 days after you ask for it. We will charge you a reasonable, cost-based fee for the records.

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- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information. We are required to give you that data except for any use or disclosure: 1) for treatment, payment and/or health care operations; 2) made with your authorization; 3) that we make to you; 4) for any national security or intelligence purposes; 5) made before April 14, 2003; or 6) that does not require your authorization. We will provide this date for you (generally within 60 days) at no charge once each year, but after that, we will require that you pay a reasonable fee-based charge for the information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information. You may ask that we limit the use and disclosure of your protected health information; we are not required to accept your request. If we do agree, however, we will do as you wish except in an emergency. You may submit your request to us in writing and tell us: 1) what information you want us to limit 2) how you want us to limit that data and 3) to whom we are to limit the access to this data.
- You have the right to request that we amend your Protected Health Information; the request must be in writing. We have the right to deny that request if you ask about medical information that 1) was not created by any of our practitioners; 2) the information is not part of the medical or billing records; 3) is not part of the records you may access or 4) the medical information is accurate and complete. We may ask that you tell us, in writing, why you want us to amend your medical information. Generally, we must act upon your request within 60 days after receipt of your request. If we agree to your request, we must make the appropriate amendment and follow the law regarding how and whom we inform about this amendment. If we do not agree, then we will tell you our reasons. You then have additional rights, including an appeal (by someone who did not participate in the decision not to allow you to amend your record) and you have the right to submit a written statement of disagreement.
- You have a right to receive all notices in writing.
- You have the right to receive confidential communication by alternative means or at alternative locations. Please make this request in writing to our Privacy Officer. We will agree, so long as your request is reasonable, but you must tell us how to communicate with you and you must give us a complete address or contact information.

If you have questions, complaints or want more information contact:
Kenneth C. Greep, Privacy Officer
1902 Rosetti Dr.
Austin, TX 78752
210-880-4372

Send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights. Information is available online at: <http://www.hhs.gov/ocr/privacyhowtofile.htm>

This notice is effective as of January 1, 2009. From time to time, we may revise our Notice. If we do, we will post the most current version in our office, and you may ask for a copy of the Notice at any time.

Kenneth C. Greep L.Ac.

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Kenneth C. Greep L.Ac. is required to have you respond to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the
Practitioner/s: Kenneth C. Greep L.Ac. of the following:

Yes No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

Yes No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

- Chronic pain
- Smoking addiction
- Weight loss
- Alcoholism
- Substance abuse

Patient Signature Required

Date

Kenneth C. Greep L.Ac. is not responsible for untrue statements made by patients.

Kenneth C. Greep L.Ac.

NEW PATIENT INFORMATION

Treatments are by appointment only. If you find that you need to cancel an appointment, it is important that we receive twenty-four (24) hours notice. This enables us to fill the time slot. We reserve the right to charge a \$25 fee for appointments canceled with less than twenty-four hours notice or for "no show" appointments.

Payment for Services Rendered

Acupuncture:

Initial Consultation: \$65 Approximate time 1.5hrs
Follow up visits: \$55 Approximate time 1 hr

Donation Clinic:

A donation clinic will be available Saturday and Sunday mornings from 7am-10:30am. The clinic is by appointment only.

Herbal consultation:

Consultation: \$20 + cost of herbs prescribed.

Payment for herbal consultation is for the consultation plus the cost of herbs prescribed. An initial herbal consultation should take approximately 30 minutes and follow-up consultations usually take 15 minutes. If you require a refill on an herbal formula prescribed during a previous treatment, we encourage you to make a follow-up appointment to determine if the formula is still appropriate for your current needs. Herbal refills may be requested in advance by phone or email.

Tuina (Asian Bodywork):

Half an hour: \$45
One hour: \$85
Two hours: \$150

Tuina is sometimes administered in the course of an acupuncture treatment at the practitioner's discretion. When this occurs, tuina hourly rates do not apply.

Patient Signature

Date

Kenneth C. Greep L.Ac.

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Kenneth C. Greep a licensed acupuncturist (L.Ac.) : acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with Kenneth C. Greep L.Ac., and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioner/s to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner/s to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Kenneth C. Greep L.Ac.

Patient's name (please print)

Patient's signature

Print Name of Patient's Representative (if applicable)

Relationship or Authority of Patient's Rep.

Signature of Patient's Representative (if applicable)

Date Signed

