Notice of Private Practices E.C.O Health Care Center Inc.

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. Protected health information (PHI), about you, is maintained as a record of your contacts or visits

Protected health information (PHI), about you, is maintained as a record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services. Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice, please contact our Privacy Manager at 513-319-1604 Greg James

Your Rights under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

• You have the right to receive, and we are required to provide you with, a copy of this Notice Of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous place within the practice, and if such is maintained by the practice, on its web site.

• You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we

would need your authorization to use or disclose your PHI for marketing purpose or for any use or disclosure of psychotherapy notes. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

•You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using a method (i.e., email, telephone, etc.), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. We will follow all reasonable requests. You must inform us in writing how you wish to be contacted (using a form provided by our practice).

• You have the right to inspect and copy your PHI - This means you may inspect and obtain a copy of PHI about you that is contained in your patient record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

• You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for, in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

• You may have the right to request an amendment to your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

• You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our

office.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make.

• Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

• Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities; or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices by notifying our office in writing.

• Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits.

• Healthcare Operations - We may use or disclose, as-needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions.

• Regional Information Organization - The practice may elect to use a regional information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may also use and disclose your PHI in the instances outlined below.

• To 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, that you identify, your PHI that directly relates to that person's involvement in your healthcare. 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 PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your Healthcare Provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your healthcare will be disclosed.

• As Required By Law - We may use or disclose your PHI to the extent that is required by law.

• For Public Health - We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

• For Communicable Diseases - We may disclose your PHI, 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.

• For Health Oversight - We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

• In Cases of Abuse or Neglect - We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI 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.

• To The Food and Drug Administration - We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, to monitor product defects or problems, to report biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance,

as required.

• For Legal Proceedings - We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

• To Law Enforcement - We may also disclose PHI, as long as applicable legal requirements are met, for law enforcement purposes.

• To Coroners, Funeral Directors, and Organ Donation - We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

• For Research - We may disclose your PHI to researchers when an institutional review board has reviewed and approved the research proposal and established protocols to ensure the privacy of your PHI.

• In Cases of Criminal Activity - Consistent with applicable federal and state laws, we may disclose your PHI 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 PHI, if it is necessary for law enforcement authorities, to identify or apprehend an individual.

• For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military service.

• For Workers' Compensation - Your PHI may be disclosed as authorized to comply with workers' compensation laws and other similar legally-established programs.

• When an Inmate - We may use or disclose your PHI if you are an inmate of a correctional

facility and your Healthcare Provider created or received your protected health information

in the course of providing care to you.

• Required Uses and Disclosures - Under the law, we must make disclosures about you when

required by the Secretary of the Department of Health and Human Services to investigate or

determine our compliance with the requirements of the Privacy Rule.

Privacy 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 Manager at E.C.O Health Care Center Inc. Greg James at 5133191604

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, ECO health center creates and maintains:

health records and other information describing, among other things, my health history, symptoms, examination and test

results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. Iunderstand that the organization reserves the right to change their Notice and practices and prior to implementation will maila copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my healthinformation may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, andauditing functions, etc.) and that the organization is not required to agree to the restrictions requested.By signing this form, I consent to the use and disclosure of protected health information about me for the purposes oftreatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

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_____

Patient's name printed Date

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Patient's signature (or guardian, if a minor) Social Security Number (for identification purposes)

_____ _____

E.C.O Health Care Center Inc. Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, E.C.O Health Care Center Inc. creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent. This consent is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law. 2. A photocopy or fax of this consent is as valid as

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_____ Patient's name printed Date

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_____ Patient's signature (or guardian, if a minor) Social Security Number (for identification purposes)

_____ Witness Signature and Date