Notice of Privacy Practices of JR WELLNESS CONSULTANTS

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Notice of Privacy Practices is always available for you to read in my office and if you would like you may request a copy to take home. The law requires that I present this notice to you and have you sign that you have access to this information.

JR Wellness Consultants is committed to protecting your privacy. Some of the things we routinely do to protect your privacy are as follows:

1. I use voice mail instead of an answering machine so that only I can hear incoming messages.
2. I inquire on my forms if I can leave messages for you on your answering machines at home and work.
3. I do not talk about you and your health information to anyone unless specifically required or requested.
4. I keep you file out of sight of other people.
5. I explicitly do not share your personal data with any company or person who may want your information for marketing purposes. I do not promote junk mail!

This Notice of Privacy Practices also describes how I may use and disclose your protected health information to carry out treatment, obtain payment or for other purposes tat are permitted or required by law. It also outlines your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, I would be happy to address them.

I am required to abide by the terms of this Notice of Privacy Practices. I have the right to revise or amend the terms of our notice at any time. The new notice will be effective for all protected health information that I have at the time and for future information. The current Notice will be made available to you.

Consent for Use or Disclosure of Health Information

I am committed to protecting your privacy. I do ***not*** routinely share my clients chart or personal information. The following is applicable primarily in insurance and workman's compensation cases. I absolutely do not rent to or share data with companies for the purpose of marketing.

The purpose of this consent form is to give Jennifer M. Rafus, _____FNP, Lic.Ac. permission to use your health information to provide treatment, collect payment, (from you or a third-party entity) and conduct the general administrative business.

There are several circumstances in which I may have to use or disclose your health care information:

- I may have to disclose your health information to another health care provided or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- I may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of our services.
- I may need to use your health information within our practice in our effort to provide you with quality health care

You have the right to limit uses or disclosures:
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let me know in writing. I am not required to agree to your restrictions. However, if I agree with your restrictions, the restriction is binding.

You have the right to revoke your authorization:
You may revoke your consent to me at any time; however, your revocation must be in writing, I will not be able to honor your revocation if I have already released your health information before I receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask the practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____
Printed Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone No: _____

SIGN BELOW ONLY IF REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X _____ X_____
Patient's Signature Date Explained by me and signed in my presence Date