Notice of Privacy Practices

Effective April 1, 2019

It is the policy of The Neuron Clinic to maintain the privacy and security of protected information our patients and employees entrust to us. Specifically, The Neuron Clinic is aware of and abides by the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economics and Clinical Health Act(HITECH) and their implementing regulations, other federal and state laws intended to protect privacy, and the contractual privacy and security requirements that apply to us.

Under HIPAA, The Neuron Clinic, must take steps to protect the privacy of your "protected health information" (PHI). PHI includes information that we have created or received regarding your health or payment for health care services. It includes both your health/mental health records and related personal information such as your name, social security number, address, and phone number We are also required to:

- Provide you with this Notice of Privacy Practices (which may be amended from time to time), and
- Follow the practices and procedures in the Notice.

Please note that while not all The Neuron Clinic services involve the collection and use of protected health information as defined by HIPAA (including mental health information), we always strive to maintain strict confidentiality of your personal information whether or not the information may be considered protected health under HIPAA rules.

Pleas acknowledge your understanding and acceptance of this Notice by signing the acknowledgment below. **Return the signed acknowledgment to the front desk or your service provider at The Neuron Clinic.**

If you have any questions about this Notice please contact your clinic service provider at The Neuron Clinic.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I [Print Name]_____, acknowledge that I received a copy of the compete Notice of Privacy Practices for The Neuron Clinic.

_____ _____

Signature of patient (or personal representative) Date

***If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:**

Representative's Name:_____

Relationship to Patient:_____

For TNC Office Use Only:

Acknowledgment of Notice of Privacy Practices could not be obtained for above named person because:

- Individual refusal to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other:_____

TNC Staff:_____ Date:_____