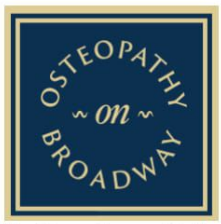

340, Broadway, Suite 1
Saratoga Springs, NY, 12866

NOTICE OF PRIVACY PRACTICES

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.

I. Our Privacy Pledge and Duties.

While we have and always will respect your privacy, a new federal law now requires us to maintain the privacy of hearing health information and other medical information (including examination, treatment and billing records) about you and to provide you with this Notice of our legal duties and privacy practices with respect to such health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change terms of our privacy notices. If we change the terms of the Notice,we will notify you during your next visit or by mail.

II.Permissible Uses and Disclosures Without Authorization.

In certain situations (described in Section III below), we must obtain your written authorization in order to use and/or disclose your health information. However, here are some examples of how we might use or disclose your health information (other than highly confidential information) without first obtaining your written authorization:

A. Uses and Disclosures for Treatment, Payment or Health Care Operations.

1.Treatment. Your health care professional or staff member may use and disclose your health information to diagnose, assess and treat your health condition.

2.Payment. Our insurance and billing staff may disclose your healthinformation to an insurance carrier, HMO, PPO, your employer, or other party that arranges or pays the cost of some or all of your health care, or to verify that such parties will pay for your health care.

3.Health Care Operations. Your health care professional and members of the staff may use or disclose your health information for quality control purposes or for other administrative purposes to efficiently and effectively run her practice.

4.Appointment Reminders. Your health care professional and members of the staff may need to use your name, address, phone number, and other health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be ofinterest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine or at another location that you reasonably request.

5.Other Providers. Your health care professional and members of the staff may use or disclose your health information to another health care provider, product manufacturer, or a hospital if it is necessary to refer you to them or they are otherwise involved in your care when such information is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosures to Relatives, Close Friends and Other Caregivers. Your health care professional and members of the staff may use or disclose your health information to one of your family members, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify your health care professional.

If you are not present, you areincapacitated or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. We may also disclose your health information to notify such persons of your location or general condition.

C.Other Permitted Uses and Disclosures Without Your Authorization. Under federal law, we are also permitted or required to use or disclose your health information without your authorization in these following circumstances:

1.Public Health Activities. Wemay disclose your health information for certain public health activities such as (i) reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (ii) reporting child abuse and neglect to authorities authorized by law to receive such reports; (iii) reporting information about products or services under the jurisdiction of the U.S. Food & Drug Administration; (iv) alerting a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition; and (v) reporting information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

2.Victim of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose health

information to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.

3.Health Oversight Activities. We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance withthe rules of government health care programs such as Medicare or Medicaid.

4.Judicial and Administrative Proceedings. We may disclose your health information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

5.Law Enforcement Officials. We may disclose your health information to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

6.Decedents. Wemay disclose your health information to a coroner or medical examiner as authorized by law.

7.Organ and Tissue Procurement. We may disclose your health information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation

8.Research. We may use or disclose your health information if an Institutional Review Board approves a waiver of authorization for use or disclosure.

9.Health or Safety. We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

10.Specialized Government Functions. We may use or disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

11.Workers' Compensation. We may disclose your health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

12.As Required by Law. We may use or disclose your health information when required to do so by any other law not already referred to in the preceding categories.

III.Uses and Disclosures Requiring Your Authorization.

A.Uses or Disclosure With Your Authorization. Other than the circumstances described above, any other use or disclosure of your health information will only be

made with your written authorization. Additionally, you have the right to refuse to give us authorization to use or disclose your health information for purposes other than those described above. If you do not give us authorization,it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

B.Your Right to Revoke Your Authorization. You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1.If we have taken an action in reliance upon such authorization beforewe receive your request to revoke your authorization.

2.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. If you wish to revoke your authorization, please write to us at the address given in Section VII below.

C. Marketing. We must also obtain your written authorization prior to using your health information to make you aware of products or services that you may have an interest in purchasing from time to time. We can, however, provide you with marketing materials in a face-to-face encounter without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without first obtaining your authorization. Additionally, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings.

D.Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you. In order for us to disclose your highly confidential information for a purpose other than permitted by law, we must obtain your written authorization.

E.Right to Refuse Authorization. You have the right to refuse to give us an authorization to use or disclose your health information or otherwise contact youfor purposes other than those set forth in Section II above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

IV.Your Individual Rights.

A.Your Right to Receive Confidential Communication Regarding Your Health Information. We normally provide information about your health in person, at the time you receive hearing care services from us. We may also mail you information regarding your health or aboutthe status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the

services that we provide by an alternative means of communication or at an alternative location. To help us respond to your needs, please make any requests in writing.

B.Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regardingyour general location and general condition. All requests for such restrictions must be made in writing. While we consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

C.Your Right to Inspectand Copy Your Health Information. You may request access to your health information maintained by us in order to inspect and/or copy your health information. We require your request to inspect an/or copy your health information to be in writing.We willcharge you for our postage costs, if you request that we mail the copies to you.

D.Your Right to Amend Your Health Information. You have the right to request that we amend your health information maintained by us. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

E.Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records. You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request, provided such requestdoes not apply to disclosures that occurred prior to March 16, 2020. The accounting will include all disclosures except those disclosures:

•required to carry out treatment, payment and health care operations.•toyou.•that are incident to a permitted use or disclosure.

•made pursuant to an authorization.

•required to maintain a directory of the individuals in our facility or to individuals involved with your care.

•required for national security or intelligence purposes.

•to correctional institutions or law enforcement officers.

•made as part of a limited data set.

•made prior to March 16, 2020.

V.Re-Disclosure.

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal law.

VII.Your Right to Obtain Further Information;Complaints.

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about

providing you access to your health information, please contact us. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the Director. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint or request information at any time, written comments should be addressed to:

Clara E. Somoza, D.O. Osteopathy On Broadway, PLLC 340 Broadway, Suite1

Saratoga Springs, NY 12866 Phone: (518) 290-0844 Fax: (518) 691-9442

VIII.Your Right to Receive a Paper Copyof this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically

.IX.Effective Date. This Notice is effective as of March 16, 2020.

340 Broadway, Suite 1,
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HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving away my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ **Date:** _____

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

Personal Representative's Name: _____ **Relationship to Patient:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the Patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my personal health information for treatment, payment, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ **Date:** _____

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PATIENT COMMUNICATION CONSENT FORM

I, _____, am:
(print name)

(Please check one)

_____ a) a patient of

_____ b) the legal representative of a patient, _____
(print patient's name)

(please initial below)

_____ I agree to allow to contact me in the following methods regarding my private health information, evaluation, and treatment. I authorize to leave messages for me when I am unavailable. I understand that messages may contain confidential information.

METHOD	NUMBER/ADDRESS	MESSAGES (YES/NO)
_____ Home Phone	(_____)_____	☐ YES ☐ NO
_____ Cell Phone	(_____)_____	☐ YES ☐ NO
_____ Work Phone	(_____)_____	☐ YES ☐ NO
_____ Alternate Phone	(_____)_____	☐ YES ☐ NO
_____ Text Messages	(_____)_____	☐ YES ☐ NO
_____ Email	_____	☐ YES ☐ NO

(please initial below)

_____ I authorize staff to discuss my healthcare information (which may include history, diagnosis, labs, evaluation findings, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

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Client Consent Form for Osteopathic Manual Treatment

Osteopathic manipulative therapy (OMT), is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of pain, neuromusculoskeletal/joint complaints, as well as for optimization of health through the balance of the structure of the human body.

Treatment will include manual therapies where the health practitioner places her hands on your body. Body and hand contact may include areas of your chest wall, pelvic floor, and pubic bones. If intraoral technique is required (work inside your mouth), disposable vinyl gloves will be worn.

Although OMT has an excellent safety record, no health treatment is completely free of adverse effects. The risks associated with OMT, however, are minimal. Many patients feel immediate relief following OMT, but some may experience mild soreness and aching, just as they do after exercise or deep tissue massage. Some may even feel an increase of their symptoms immediately after treatment as their bodies adjust and start releasing tensions. Current literature shows that minor discomfort or soreness following soft tissue therapy typically fades in 24 hours. If symptoms persist over 48 hours, please notify your Osteopath.

Certain therapies like Fascial Distortion Model (FDM) may cause redness, inflammation, and even bruising, however, this more intense therapy usually leads to quicker pain relief, when applicable.

I understand that I can refuse or stop the treatment at any time if it is uncomfortable.

If I do not fully understand a manual procedure or its risks, consequences, or alternative approaches to treatment, I have the right to question my osteopathic physician.

I, (print Name) _____, have had full opportunity to read and consider the contents of this consent form. I understand that by signing this form, I am giving consent for medical treatment.

Signature_____ Date __/__/____

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

Print Parent/Guardian Name_____

Signature_____ Date __/__/____