

Glastonbury Naturopathic Center LLC

18 School Street Glastonbury, Ct. 06033
860-657-4105

Helene Pulnik, ND
Naturopathic Physician

HIPAA

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

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (1) maintain the privacy of medical information provided to us; (2) provide notice of our legal duties and privacy practices; and (3) abide by the terms of our Notice of Privacy Practices currently in effect.

Who Will Follow This Notice

This notice describes the practices of our employees and staff as well our business associates. This notice applies to each of these individuals, entities, research personnel, and satellite office locations. In addition, these individuals, entities, sites, and locations may share medical information with each other for treatment, payment and health care operation purposes described in this notice.

Information Collected About You

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

Your name, address, and phone number.

..Information relating to your medical history. .Your insurance information and coverage.

.Information concerning your doctor, nurse or other medical providers.

.Names of family members and/or friends we may speak with on your behalf.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" - such as the referring physician, your other doctors, your health plan, and close friends or family members.

How We May Use and Disclose Information About You

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIP AA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below-

For Treatment. We may use health information about your treatment. For example, we may use your medical history, such as any presence or absence of heart disease, to assess your health and perform requested ultrasound or other diagnostic services.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payor information about your current medical condition so that it will pay us for the examinations or other services that we have furnished you. We may also need to inform your payer of the tests that you are going to receive in order to obtain prior approval or to determine whether the service is covered.

For. Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for accountants, attorneys, auditors or other consultants to review our facility, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.

Public Policy Uses and Disclosures. There are a number of public policy reasons why we may disclose information about you, which are described below.

We may disclose health information about you when we are required to do so by federal, state, or local law.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury or disability, or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and Health Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls; repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to a communicable disease or to an employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorizes the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies which are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or 4) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including in response to a warrant, subpoena, or other order of a court or administrative hearing body, or to assist law enforcement to identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes also permit us to make disclosures about victims of crimes and the death of an individual, among others.

We may release a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors. We also may release personal health information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.

We may release your health information to workers' compensation or similar programs, which provides benefits for work-related injuries or illnesses without regard to fault.

Health information about you may will be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We also may release personal health information about foreign military personnel to their appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order .

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information ,is necessary for your treatment, health or safety, or the health and safety of others.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

.Our Business Associates. We sometimes work with outside individuals and businesses who help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.

.Disclosures to Persons Assist in in Your Care or Payment of Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your circle of care" -such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

If State Law or another Federal Law is more stringent, then we will disclose in accordance with those laws.

Additional Optional Disclosures

.A Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.

.Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

Fundraising We may use your protected health information to contact you in an effort to raise funds for our operations.

Clinical Research. We may use certain information about your clinical condition for the purpose of research study.

Other Uses and Disclosures of Personal Information

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent we have already relied on your permission.

Individual Rights

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting in your care or payment for your care. We will consider your request, but we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical, billing records and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete. You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations; disclosures to you; disclosures you give us authorization to make and uses and disclosures before April 14, 2003, among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have the right to a copy of this notice in paper form. You may ask us for a copy at any time. You may contact our Privacy Officer at Glastonbury Naturopathic Center, telephone #860-657-4105. To exercise any of your rights, please contact us in writing at Glastonbury Naturopathic Center, LLC, 2906 Main Street, Glastonbury, Ct. 06033. When making a request for amendment, you must state a reason for making the request.

Changes To This Notice

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised I notice at any time.

Complaints/Comments

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). You also may contact us at Glastonbury Naturopathic Center, LLC, 2906 Main Street, Glastonbury, Ct. 06033. c/o Privacy Officer.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

This notice is effective as of April 14th, 2003.

Glastonbury Naturopathic Center LLC

18 School Street Glastonbury, Ct. 06033
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Helene Pulnik, ND
Naturopathic Physician

HIPAA**Written Acknowledgement of Receipt of Notice of Privacy Practices**

Patient Name _____

Date _____

I, (Print Name) _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

Glastonbury Naturopathic Center, LLC ; Attention: Privacy Officer 18 School Street, Glastonbury, Ct. 06033.

I also understand that I am entitled to receive updates upon request if the Glastonbury Naturopathic Center's Notice of Privacy Practices is amended or changed in a material way.

Signature _____

Relationship to the Patient _____

Date _____

**TO BE COMPLETED BY Glastonbury Naturopathic Center IF UNABLE TO OBTAIN WRITTEN
ACKNOWLEDGEMENT FROM PATIENT**

On (date) _____ I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgement.

Patient did not understand the request to sign the Written Acknowledgement.

Other (specify) _____

Name and Title of Provider/Contractor/Staff Member _____

Date _____

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Naturopathic Physician

HIPAA

Restriciton of Use or Disclosure of Protected Health Information

Glastonbury Naturopathic Center, LLC, is dedicated to maintaining our Privacy Policy and your Protected Health Information.

To that end, we may need to communicate the results of our evaluation and/or treatment to your Referring Physician, Primary Care Physician, and other specialists directly involved in the care we are providing.

If this policy is not acceptable to you, please indicate your reason below:

If you wish to allow your protected health information sent to and/or discussed with another physician, relative or family friend, and/or third party provider, **please print their names** in the spaces provided below:

1. Physicians-Please print names:

2 .Relatives/Family Friends-Please print names and relationship:_____

3. Other Healthcare Providers-therapist, social worker, etc.-please print names:

4. May we leave a message on your answering machine reminding you of an appointment:

Yes

No

5. May we mail or e-mail information about our services and workshops/lectures to you:

Yes

No

Signature-Patient (or guardian if under 18)

Date

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Helene Pulnik, ND
Naturopathic Physician

Naturopathic Medicine- Informed Consent/Consent to Treat

I, the undersigned, authorize Dr. Helene Pulnik, ND to perform the following specific treatment(s)/procedure(s) and I recognize the potential risks and benefits of these treatment(s)/procedure(s) as described below:

Clinical Nutrition and Dietary Advice:

The use of food, vitamins, nutrients and food supplements.

Botanical Medicine:

The use of herbs, in the form of tablets, capsules, tinctures, teas, suppositories, salves, sprays and oils orally or topically.

Homeopathy:

The use of extremely dilute substances.

Laboratory testing:

For screening and diagnostic purposes.

Lifestyle Change and Stress Management:

Recommendation of steps to take to enhance your life and reduce stressors.

Potential risks:

Possible aggravation of symptoms existing prior to the treatment, sensitivity or allergy, digestive distress, appetite changes, bruising from phlebotomy, energy changes, other:_____.

Potential benefits:

Relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem.

I affirm that I understand the purpose and potential benefits of my treatment(s).

I understand and freely accept the potential reasonable foreseeable risks of the treatment(s).

An offer has been made to answer my questions about the treatment(s).

The reasonable alternative(s) to the treatment(s) have been explained to me.

I freely and voluntarily consent to the above treatment(s).

I agree to make a reasonable effort to adhere to my treatment plan and attend follow-up visits to permit observation and study of my progress.

I realize that no guarantee as to the results that may be obtained have been given to me by Glastonbury Naturopathic Center, LLC, or Helene Pulnik, ND.

I hereby release Glastonbury Naturopathic Center, LLC and Helene Pulnik, ND from any and all liability which may occur in connection with the above mentioned treatment(s).

I understand that I am free to withdraw my consent and to discontinue participation in this procedure at any time.

Signature of Patient or Guardian (if under age 18)

Date

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Helene Pulnik, ND
Naturopathic Physician

I AUTHORIZE Glastonbury Naturopathic Center, LLC, TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT, AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT SUCH CHARGES ARE REIMBURSED BY INSURANCE, INCLUDING CHARGES FOR WHICH I FAILED TO OBTAIN A REFERRAL.

Signature of Patient (or Responsible Party) _____ Date _____
