SOLUNA HOLSITIC HEALTHCARE, INC.

PRIVACY/HIPPA

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.

At SOLUNA HOLISTIC HEALTHCARE, we understand that your medical information about you and your health is personal. Our practice is committed to protecting your medical information. We are required by federal and state laws to maintain the privacy of your Protected Health Information (PHI) and to give you this notice explaining our privacy practices with regard to your information. This notice explains your rights and our legal obligations regarding the privacy of your PHI.

Protected Health Information is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another healthcare provider, your health plan, your employer or a healthcare clearing house that relates to (1) past, present or future physical conditions, (2) the provision of healthcare to you, or (3) the past, present or future payment for your health care.

How We May Use and Disclose Your Protected Health Information:

1. Treatment: Your PHI may be provided to a healthcare provider to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide a service.

2. Payment: Your PHI may be used and disclosed to enable us to bill and either collect payment from you, a health plan or a third party for the treatment and services you receive from us. As an example, we may need to give your health plan information of your treatment in order for your health plan to agree to payment for that treatment.

3. Health Care Operations: We may use and disclose your PHI in order to support the business activities of your provider's office. The activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to healthcare providers, medical technicians, medical students and other authorized personnel for education and learning purposes.

4. Appointment Reminders/Treatment Alternatives/ Health-Related Services: We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.

5. As required by Law: We will disclose your PHI about you when required to do so by international, federal, state or local law. Examples include:

- Public health activities including reporting of certain communicable diseases,
- Workers' compensation or similar programs as required by law,
- Authorities when we suspect abuse, neglect, or domestic violence,
- Health oversight agencies,

- For certain judicial and administrative proceedings pursuant to an administrative order,
- Law enforcement purposes,
- Medical examiner, coroner, or funeral director,
- The facilitation of organ, eye, or tissue donation if you are an organ donor,
- To avert a serious threat to your health and safety or that of others,
- For governmental purposes such as military service or for national security; and
- In the event of an emergency or for disaster relief

6. Marketing & any purposes which require the sale of your information: These disclosures require your written authorization.

7. Business Associates: We may share your PHI with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering or quality assurance. Our Business Associates agree to protect the privacy of your information.

8. Any other uses and Disclosures not recorded in this Notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Form 164.520-A

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF SOLUNA HOLISTIC HEALHTCARE, INC. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. The Right to Inspect and Copy: Under federal law you have the right to inspect and copy your PHI and SOLUNA HOLISTIC HEALHTCARE, INC has up to 30 days to make your PHI available to you, fees may apply.

2. The Right to an Electronic Copy of Electronic Medical Records: You have the right to request that an electronic copy of your PHI be given to you or transmitted to your designated officer. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fee may apply).

3. Restrictions on Use and Disclosure: You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. You may ask us not to use or disclose any part of your PHI and by laws we must comply when the PHI pertains solely to health care item or service which the health care provider involved has been paid out of pocket in full. Your request must be made in writing to our HIPAA Compliance Officer with specific instructions. If we agree to the restriction, we may only be in violation of the restriction for emergency treatment purposes. By law, you may not request we restrict the disclosure of your PHI for treatment purposes.

4. The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured PHI.

5. The Right to Request Amendments: If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be in writing to the HIPAA Compliance Officer at the information at the end of this Notice. In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy.

6. The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred six years prior to the date of the request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically. The first accounting of disclosures in any 12 month period will be free. Any additional requests within that same period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

7. The Right to Request Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

8. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact SOLUNA HOLISITIC HEALTHCARE's Privacy Officer. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy or have read a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

____

Printed Patient Name   Name/Relationship if Signed by Individual Other than Patient

____

Signature   Date

*****FOR OFFICE USE ONLY***   We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:**

_____ Individual Refused to Sign   _____ Communication Barrier

_____ Care Provided was Emergent _____ Other: _______________________

Employees Initials/Date_____________________