RIVERSTONE
WELLNESS CENTER

NEW CLIENT INFORMATION

DATE: _____ REFERRED BY: _____

FIRST NAME: _____ MI: _____ LAST NAME: _____

AGE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ EMAIL: _____

CELL #: _____ HOME #: _____

EMPLOYER: _____ WORK #: _____

RACE / ETHNICITY: _____

GENDER (circle): Female Male Transgender Gender Fluid

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT RELATIONSHIP TO YOU: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN ADDRESS: _____

PRIMARY INSURANCE: _____ ID #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ DOB: _____ SOC SEC #: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ DOB: _____ SOC SEC #: _____

MARITAL STATUS (circle): Single Partnered Married Divorced Widowed

NUMBER OF MARRIAGES: ____ NUMBER OF CHILDREN: ____ AGES OF MINOR CHILDREN: _____

SEXUAL ORIENTATION (circle): Heterosexual Bi-sexual Lesbian Gay Queer Questioning Asexual

FIRST NAME: _____ MI: _____ LAST NAME: _____

HIGHEST LEVEL OF EDUCATION (circle):

HS DIPLOMA GED SOME COLLEGE ASSOCIATES DEGREE BACHELORS GRADUATE DEGREE

OTHER: _____

RELIGION AND SPIRITUALITY:

- ☐ NONE
- ☐ SPIRITUAL, BUT NOT RELIGIOUS
- ☐ PROTESTANT CATHOLIC JEWISH MUSLIM BUDDHIST HINDU (please circle, if appropriate)
- ☐ OTHER: _____

PLEASE CIRCLE TO INDICATE THE IMPORTANCE OF RELIGION / SPIRITUALITY IN YOUR LIFE:

NONE SOME IMPORTANCE MODERATE IMPORTANCE VERY IMPORTANT

PLEASE CHECK ALL THAT APPLY:

- ☐ LOW ENERGY LEVEL
- ☐ LOW SELF-ESTEEM
- ☐ SLEEPING TOO MUCH
- ☐ SADNESS / DEPRESSION
- ☐ RECENT WEIGHT GAIN OR LOSS
- ☐ PREOCCUPATION WITH BODY IMAGE
- ☐ WITHHOLDING FOOD / BINGE EATING
- ☐ PURGING / INDUCING VOMITING
- ☐ RECENT LOSS OF LOVED ONE
- ☐ STRUGGLES WITH SEXUALITY (LGBTQ ISSUES)
- ☐ STRUGGLES WITH GENDER IDENTITY
- ☐ ABUSIVE TOWARD OTHERS, MANIPULATIVE
- ☐ COMPULSIVE SPENDING / GAMBLING
- ☐ RISK-TAKING BEHAVIORS (RISKY DRIVING, SEX, DRUGS, ETC.)
- ☐ REPETITIVE BEHAVIORS (HAND WASHING, COUNTING. ETC.)
- ☐ SELF-HARMING BEHAVIORS (CUTTING, PICKING, ETC.)
- ☐ LOSS OF INTEREST IN HOBBIES / ACTIVITIES
- ☐ DISCOMFORT IN SOCIAL SETTINGS
- ☐ TROUBLE FALLING / STAYING ASLEEP
- ☐ POOR CONCENTRATION OR MEMORY
- ☐ IRRITABILITY / ANGER PROBLEMS
- ☐ REPEATED, INTRUSIVE OR UNWANTED THOUGHTS
- ☐ FREQUENT NIGHTMARES
- ☐ EXCESSIVE WORRY / ANXIETY
- ☐ THOUGHTS ABOUT SUICIDE
- ☐ THOUGHTS OF HARMING OTHERS
- ☐ POUNDING HEART
- ☐ SHORTNESS OF BREATH
- ☐ ADULT INTERPERSONAL TRAUMA (PHYSICAL / SEXUAL / EMOTIONAL)
- ☐ CHILDHOOD NEGLECT OR ABUSE (PHYSICAL / SEXUAL / EMOTIONAL)
- ☐ WORKPLACE TRAUMA (COMBAT, POLICE, FIRE, ACCIDENT, ETC.)
- ☐ OTHER: _____

SUBSTANCE USE:

IN AN AVERAGE WEEK…

- HOW MANY DAYS A WEEK DO YOU CONSUME ALCOHOL? _____
- HOW MANY DRINKS DO YOU CONSUME IN A GIVEN DAY? _____
- TYPICAL DRINK (BEER, WINE, MIXED, STRAIGHT, ETC)? _____
- HOW MANY DAYS A WEEK DO YOU USE ILLEGAL DRUGS? _____
  - TYPE(S) OF ILLEGAL DRUG(S): _____
- DO YOU TAKE PRESCRIPTION DRUGS OTHER THAN AS PRESCRIBED? Y N

FIRST NAME: _____ MI: _____ LAST NAME: _____

HAVE YOU EVER BEEN <u>HOSPITALIZED</u> FOR THE FOLLOWING REASONS?

- ☐ SUICIDAL THOUGHTS, PLEASE PROVIDE DATES: _____
- ☐ HOMICIDAL THOUGHTS, PLEASE PROVIDE DATES: _____
- ☐ SUBSTANCE ABUSE, PLEASE PROVIDE DATES: _____
- ☐ IMPULSIVE BEHAVIORS (RECKLESS DRIVING, SELF-HARM BEHAVIORS, FIGHTING, MANIA)
  _____
- ☐ VIOLENCE TOWARD OTHERS, PLEASE PROVIDE DATES: _____
- ☐ OTHER BEHAVIORAL HEALTH REASONS: _____

ARE ANY OF THESE AREAS OF LIFE STRESSFUL FOR YOU?

☐ Marriage / Relationship	☐ Legal	☐ Employment	☐ School / Education
☐ Physical Health	☐ Finances	☐ Spirituality	☐ Family
☐ Parenting	☐ Sex	☐ Other: _____	

CURRENT MEDICATIONS AND DOSAGES (INCLUDE OVER THE COUNTER MEDICATIONS TAKEN ROUTINELY):

_____

_____

MEDICAL CONDITIONS, PLEASE CHECK ALL THAT APPLY:

- ☐ ASTHMA/SEASONAL ALLERGIES/LUNG CONDITION, PLEASE DESCRIBE: _____
- ☐ ARTHRITIS
- ☐ BARIATRIC SURGERY
- ☐ CANCER
- ☐ CHRONIC PAIN, PLEASE DESCRIBE: _____
- ☐ DIABETES
- ☐ DIGESTIVE SYSTEM PROBLEMS, PLEASE DESCRIBE: _____
- ☐ FOOD ALLERGIES/SENSITIVITIES/AVERSIONS, PLEASE DESCRIBE: _____
- ☐ HIGH OR LOW BLOOD PRESSURE
- ☐ HIGH LDL CHOLESTEROL
- ☐ HIV/AIDS
- ☐ MENOPAUSE
- ☐ MIGRAINE HEADACHES
- ☐ TACHYCARDIA OR OTHER HEART RATE IRREGULARITIES
- ☐ THYROID PROBLEMS
- ☐ TRAUMATIC BRAIN INURY, PLEASE DESCRIBE: _____
- ☐ OTHER: _____

MEDICAL STATS: HEIGHT: _____ CURRENT WEIGHT: _____

HIGHEST WEIGHT IN PAST 36 MOS: _____ LOWEST WEIGHT IN PAST 36 MOS: _____

IF FEMALE, DATE OF LAST PERIOD: _____ CURRENTLY PREGNANT? Y N UNSURE

FIRST NAME: _____ MI: _____ LAST NAME: _____

HAVE YOU BEEN HOSPTALIZED FOR MEDICAL REASONS IN THE LAST 5 YEARS? Y N

IF YES, PLEASE DESCRIBE: _____

_____

PREFERRED METHOD OF CONTACT:

- ☐ Phone (voice calls, not text) - Best number to reach me: _____
- ☐ Email
- ☐ Postal mail to home address

Contact for Appointment Reminders

As a courtesy, RiverStone Wellness Center routinely sends appointment reminders to clients via email. Please let us know your preference:

- ☐ I wish to receive automatic email appointment reminders
- ☐ I do not wish to receive automatic email appointment reminders

RELEASE OF INFORMATION

Do you wish to release your RiverStone Wellness Center mental health treatment information to a third party, such as a relative, friend, or agency?

- ☐ YES: _____
  (please request a formal *Release of Information* form at your first appointment.)
- ☐ NO

***By my signature below, I attest that the information provided by me in this document is true and correct, to the best of my knowledge*.**

_____ _____

Client Signature Date

_____

Printed Client Name

RiverStone Wellness Center, PLLC

FINANCIAL AGREEMENT POLICY

Thank you for choosing RiverStone Wellness Center as your behavioral health care provider. The following is our center's statement of financial policy. It is required that all clients read and sign this agreement prior to any treatment.

PAYMENT OF DEDUCTIBLES, CO-PAYMENTS AND FOR ANY NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. NON-INSURED CLIENTS ARE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, DEBIT, VISA, MASTERCARD, and DISCOVER. A $35 FEE WILL BE CHARGED FOR ANY RETURNED CHECK**. EVENING AND WEEKEND (FRI-SUN) CLIENTS WILL BE REQUIRED TO HAVE A DEBIT OR CREDIT CARD ON FILE FOR BILLING PURPOSES. SERVICE FEES FOR WEEKEND APPOINTMENTS WILL BE PROCESSED ON THE NEXT BUSINESS DAY.**

INSURANCE

If your RiverStone Wellness Center provider is in-network with your healthcare company, we will handle your claims according to our agreement with your particular health insurance carrier. You are responsible for paying all co-payments, deductibles, and for any non-covered services on the day of your visit. In the event that we accept assignment of benefits, you are still ultimately responsible for all charges. We do not become involved in disputes with insurance companies. If your insurance plan has not paid within a reasonable time frame, you will be responsible for payment. Our practice is committed to providing the best treatment for our clients and we charge what is usual and customary in our area. You are responsible for your portion of the payment regardless of any insurance company's determination of usual and customary rates. Our standard fees are as follow:

PSYCHOTHERAPY	LCSW PHD
New client intake evaluation	$225 - $250
New family intake evaluation	$250 - $275
30-min psychotherapy	$ 80 - $110
45-min psychotherapy	$110 - $145
60-min psychotherapy	$155 - $210
90-min psychotherapy	$210 - $275
Group psychotherapy	$55 per session

PSYCHOLOGICAL EVALUATIONS	
Diagnostic Interview	$250
Psychological Testing	$200/hour

REGISTERED DIETITIAN SERVICES	
DISCOUNT PACKAGES AVAILABLE	
Individual Nutrition Evaluation	$200
Family Nutrition Evaluation	$250
Follow-Up Nutrition Counseling	$90 - $180
Meal Planning	$60 per week
Grocery Shopping Tours	$125 - $200
Restaurant Trip Sessions	$200

MINORS

The adult accompanying a minor client is responsible for full payment, regardless of any divorce decree. If the non-accompanying parent/guardian is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the provider's fees and may collect reimbursement from the other parent/guardian. Parents/guardians are responsible for sending payments for services provided to unaccompanied minors at each visit.

AUTHORIZATION TO BILL INSURANCE CARRIER

Your signature below authorizes RiverStone Wellness Center, PLLC to bill your healthcare and/or workman's compensation insurance carrier for all healthcare services provided to you by RiverStone Wellness Center healthcare providers. Your signature also indicates that you agree that RiverStone Wellness Center, PLLC may accept assignment for payment of benefits related to such healthcare services provided, where applicable.

DELINQUENT ACCOUNTS

I agree to be financially responsible for any unpaid balance due to RiverStone Wellness Center, PLLC for services rendered. I understand that, even if I have insurance, some diagnoses may not be covered under my insurance. If this occurs, I agree to pay the full fee for services. I grant permission to RiverStone Wellness Center, PLLC, its agents to discuss my account with, and release any information to, any third party payer via the US Postal Service, fax, or electronic media in order to assist in the payment of any balance due, or otherwise verify personal information provided. Also, it is understood and agreed that RiverStone Wellness Center, PLLC reserves the right to assess a monthly finance charge, in accordance with Arkansas Law, for any unpaid balance due. Further, it is agreed that should RiverStone Wellness Center, PLLC determine that it is necessary to employ a collection agency to recover any unpaid balance owed, I agree to pay any and all collection fees and costs expended to effect recovery, with such collection fees to be up to 50% of the unpaid balance due, including any and all attorney's fees assessed by any court.

NON-COVERED SERVICES

There will be an hourly fee charged to you based upon the standard fee schedule above, for FMLA, disability, or other forms not filled out during your appointment time. As a general rule, insurance companies do not pay for this charge.

PLEASE PROVIDE RIVERSTONE WELLNESS CENTER, PLLC AT LEAST 24 HOURS NOTICE IF YOU ARE UNABLE TO ATTEND YOUR APPOINTMENT. YOU MAY BE CHARGED A $35 LATE CANCELLATION FEE IF LESS THAN 8 HOURS NOTICE IS PROVIDED. I UNDERSTAND I AM FULLY RESPONSIBLE FOR THIS FEE, AS INSURANCE COMPANIES DO NOT COVER LATE OR MISSED APPOINTMENT FEES. FAILURE TO SHOW UP FOR AN APPOINTMENT WITH NO ADVANCE NOTICE WILL RESULT IN BEING CHARGED THE ENTIRE THERAPY FEE FOR THAT APPOINTMENT. TWO MISSED APPOINTMENTS WITH NO NOTIFICATION MAY RESULT IN DISMISSAL FROM THERAPY.

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING. YOUR SIGNATURE INDICATES YOUR AGREEMENT TO ABIDE BY THIS POLICY.

_____ _____

CLIENT (OR RESPONSIBLE PARTY SIGNATURE) DATE

_____ _____

PRINTED CLIENT NAME DESCRIBE AUTHORITY OF RESPONSIBLE PARTY

RIVERSTONE
WELLNESS CENTER

Welcome to Discreet Check Out

Please indicate your preferred method of payment for services:

- ☐ American Express
- ☐ Discover
- ☐ MasterCard
- ☐ VISA

Card number: _____

Expiration date: _____ CVC/CVV Code: _____

I authorize RiverStone Wellness Center to automatically process payments for

- ☐ my RiverStone Wellness Center account DOB: _____
- ☐ the account of _____ DOB: _____

I understand that my credit or debit card referenced above will be charged the agreed upon amount (including health insurance copays, deductible, coinsurance, self-pay amounts, non-reimbursable fees) for services and fees related to clinic appointments. This authorization will remain in effect unless and until I revoke this permission in writing, which I may do without notice.

Name as it appears on card: _____

Card Billing Address: _____

_____

Signature of card holder: _____ Date: _____

FOR OFFICE USE ONLY: CARD IMPRINT ON FILE? YES / NO

RiverStone Wellness Center, PLLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I UNDERSTAND THAT RIVERSTONE WELLNESS CENTER'S NOTICE OF PRIVACY PRACTICES, AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), INFORMS ME OF HOW THIS OFFICE USES AND DISCLOSES MY PROTECTED HEALTH INFORMATION (PHI) AS PERMITTED UNDER FEDERAL AND STATE LAW. THIS NOTICE ALSO OUTLINES MY RIGHTS REGARDING MY PROTECTED HEALTH INFORMATION (PHI).

RIVERSTONE WELLNESS CENTER'S NOTICE OF PRIVACY PRACTICES WAS PRESENTED TO ME TODAY. I ACKNOWLEDGE THAT I HAVE READ THIS AND BEEN OFFERED A COPY OF THE PRIVACY PRACTICES OF RIVERSTONE WELLNESS CENTER, PLLC.

PLEASE SELECT AND INITIAL BELOW:

I HAVE **RECEIVED** A COPY OF THE PRIVACY PRACTICES _____
(INITIALS)

I HAVE **DECLINED** A COPY OF THE PRIVACY PRACTICES _____
(INITIALS)

_____ _____

CLIENT (OR RESPONSIBLE PARTY SIGNATURE) DATE

_____

PRINTED NAME OF CLIENT

RiverStone Wellness Center, PLLC

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. A new Notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. Copies of this Notice are available from your provider or by mail.

1. Uses and Disclosures of Protected Health Information:

Uses and Disclosures of Protected Health Information for Which Your Authorization Is Not Required. Your PHI may be used and disclosed without your prior authorization by your provider, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, obtaining your medical treatment and history and recording it in your chart and discussing your care with another behavioral health provider to which you have been referred to ensure that the therapist has the necessary information to diagnose or treat you

Payment: Your PHI will be used, and discloses as necessary, to obtain payment for your health care services. For example, to obtain authorization for your healthcare insurance plan to pay for additional therapy sessions it may be may require that your protected health information be provided to a managed care representative for that determination.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to graduate students who see clients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to identify yourself in some manner and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We will share your PHI with third-party business associates who perform various activities for RiverStone Wellness Center and for your provider, These business associates will have signed HIPAA privacy agreements to strictly protect your PHI. For example, a contract with a collections agency that handles past due accounts.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Opportunity to Object. We may use and disclose your PHI in the following instances. You have the opportunity to object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's direct involvement in your health care. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for the care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your healthcare provider or another healthcare provider in our agency is required by law to treat you and the healthcare provider has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object. We may disclose your PHI in the following situations without your consent or authorization:

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury, or disability.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration (i) to report adverse events, product defects or problems, biologic product deviations, track products; (ii) to enable product recalls; (iii) to make repairs or replacements; or (iv) to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose your PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may use or disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel: (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of a determination by the Department of Veterans Affairs; or (iii) to foreign military authority if you are a member of the foreign military services.

Workers' Compensation: We may use or disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs. Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your health care provider created or received your PHI in the course of providing care to you.

Fundraising: Though permissible by federal law, we will not contact you for fundraising purposes.

Required Uses and Disclosures: Under the law, we must make disclosures to you, and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with requirements of the Code of Federal Regulations, Part 45 Section 164.500 et seq.

Uses and Disclosures of PHI for which Your Written Authorization Is Required. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You make revoke this authorization, at any time, in writing, except to the extent that your provider or RiverStone wellness Center has already taken an action in reliance on the use or disclosure indicated in the authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; and (iii) other uses and disclosures not described in this Notice of Privacy Practices.

2. <u>Your Rights</u>. Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:

<u>You have the right to inspect and copy your protected health information</u>. This means you may inspect and obtain a copy of your PHI that is contained in a designated record set for so long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your health care provider and RiverStone Wellness Center uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

<u>You have the right to request a restriction of your protected health information</u>. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You also have a right to restrict certain disclosures of your PHI to a health plan if you have paid in full out-of-pocket for the health care item or service. Your health care provider is not required to agree to a restriction that you may request.

If your health care provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider. If your health care provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, 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 with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record. If we deny your request for amendment, 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 with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for general notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this Notice of Privacy Practices from us. You have a right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically.

You have a right to receive notifications of a data breach. We are required to notify you upon a breach of any unsecured PHI. PHI is "unsecured" if it is not protected by a technology or methodology specified by the Secretary of Health and Human Services. The notice must be made within 60 days from when we become aware of the breach. However, if we have insufficient contact with you, an alternative notice method (posting on website, broadcast media, etc.) may be used.

3. Complaints. You may complain to us or to the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201, if you believe your privacy rights have been violated by us. You may file a complaint with our Privacy Officer at RiverStone Wellness Center, PLLC, 5905 Forest PL., Ste. 230, Little Rock, AR 72207-5244. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of PHI, to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI.

If you have any objections to this form, please contact our Privacy Officer at RiverStone Wellness Center, PLLC, 5905 Forest Pl., Ste. 230, Little Rock, AR 72207-5244.

This notice became effective on February 9, 2016.