Name: Date:

HIPAA Notice of Privacy Practices

Sage Medical Group, PLLC
12600 SE 38th ST, Suite 130
Bellevue, WA 98006
425-728-8363

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 (TPO) 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" 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.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of 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 physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as Required by Law, Public Health issues as required by lay, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings: Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, 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 the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Name: Date:

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal lay, 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 protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of 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.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health care information. If we deny your request for amendment, you have the right to file a statement of disagreement with is 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.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

State Mandated Exemptions:

- We are required by Washington State Law to disclose health information to the Department of Labor & Industries or a self-insured employer for workers' compensation or crime victims' claims.
- We can disclose health information to an employer about light duty work without a patient authorization.
- We can disclose health information to an employer without a patient authorization if that information is about a workplace injury or illness, a workplace medical surveillance, or a return-to-work examination.
- Because these disclosures to the department or self-insurer are required by law, patients cannot object to or request that we restrict those disclosures (45 CFR, 164. 522(a)(1)(v)).

Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by use. You may file a complaint with us by notifying Sage Medical Group, PLLC of your complaint. We will not retaliate against you for filling a complaint.

This notice was published and becomes effective on October 1st, 2010.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Sage Medical Group, PLLC in person or by phone at our main phone number.

Print Name Signature Date

SageMED
Non-Covered Services Agreement

I would like to take this time to welcome you to the community of SageMED. We are happy to be of service to you. Due to the growing demand for integrative medicine we are happy to offer you a variety of treatments to complement your lifestyle and optimize your health. Unfortunately, not all of these services are necessarily covered by your insurance plan at this time. In order to assure that the highest quality of health care is available to you, we are making a number of services available for a cash payment at the time of service. Our commitment to you is that we will keep the cost as low as possible.

We are required to have you sign a waiver relating that you understand some services such as acupuncture, B12 shots, and massage may not be a part of your insurance plan. Supplements are also not covered by insurance. We encourage you to be aware of what your insurance benefits include to best utilize services that are covered under your plan. We also want you to rest easy knowing that we will make many popular services easily accessible to you even if they are not covered by your insurance.

Non-Covered Services Agreement:

I understand that I may obtain treatments on a cash payment basis that are not covered by my insurance plan:

Name: _____

Signature: _____

Name: Date:

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, have insurance coverage with Name of Insurance Company

And assign directly to Sage Medical Group, PLLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Sage Medical Group, PLLC to release all information necessary to secure the payment benefits. I give permission to the Sage Medical Group, PLLC to release information to my other health care providers. I authorize the use of this signature on all my insurance submissions.

X _____ Date _____
Signature of Insured / Guardian

CONSENT TO TREATMENT

It is our philosophy that patients should have full disclosure when receiving any type of health care. We therefore ask that you read and sign the following consent. We also feel that any individual should request the same full disclosure from any other health care provider and their proposed treatment plan. Educated choices are the only choices.

I understand that as a patient of Sage Medical Group, PLLC, I will receive an initial evaluation, and thorough discussion of treatment options. The goal of the initial evaluation process is to determine the best course of treatment for me. I understand that typically, treatment is provided over the course of several weeks to months.

I understand that all information shared with the healthcare providers is confidential and that no information will be released without my consent. During the course of treatment, it may be necessary for my providers to communicate with other healthcare practitioners. I understand that consent to release information is given through written authorization. Verbal consent for release of limited and essential information may be necessary in special circumstances.

I understand that while treatment may provide significant benefits, it may also pose risks. Short of overt negligence, I agree to hold Sage Medical Group, PLLC harmless in case of undesirable effects of undertaking or discontinuing treatment. I also understand that I may stop treatment at any time.

Please note: If applicable, co-pays are due at each visit. I also understand that unless other arrangements have been made ahead of time, payment in full is due at the end of each treatment.

I also understand that a given provider may have financial interest in any referral given to another provider in the clinic (Urban Oasis Yoga & Wellness) as an owner, partner, group owner or shareholder.

If a provider in our office recommends other forms of treatment, it is at your discretion to choose one of our in office providers, or an external provider.

It is your right to have a chaperone in the room during your exam. We will provide someone upon request.

If I have any questions regarding this consent form or about the services offered, I am encouraged to discuss them with the treating healthcare provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by the individual healthcare providers. I understand that I have the right to suspend any treatment at any time but that if this suspension of treatment is against medical advice that the consequences of my decision are my own responsibility.

X _____ Date _____
Signature of Insured / Guardian

REQUEST FOR RELEASE OF MEDICAL RECORDS

NAME OF PATIENT: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

I hereby request that _____
(Indicate the name of the relevant health care provider and clinic or hospital)

Address / Fax _____
(Please indicate the clinic's address and fax number if possible)

(FOR CLINIC USE ONLIY)

Release:

- ☐ Imaging and reports related to _____
- ☐ Blood work / Laboratory tests
  - ☐ within last ____ years / months
  - ☐ other _____
- ☐ Complete medical file
- ☐ Specific Records _____

To: SageMED
12600 SE 38th ST, Suite 130
Phone: (425) 728-8363
Fax: (425) 728-8364

Patient has the right to revoke request in writing.

Once received these records could be re-disclosed to another party upon request.

I understand that this authorization unless expressly limited by me in writing will extend to all aspects of treatment including testing and treatments.

This authorization ends in 90 days from the date signed.

Patient Signature: _____ Date: _____

CONSENT FOR EXAMINATION

I understand that various physical exams are conducted by the doctors of SageMED.

I understand that as part of the physical exam I may be asked to wear a gown, to disrobe or to expose body parts.

I understand that this exam may include physical contact and/or exposure of various body parts that may be considered sensitive or private (e.g. genitalia).

I understand that it is my right to refuse any form of examination prior to or during the examination for whatever reason.

I understand that this refusal may compromise the capacity of the doctor to diagnose my health problem.

I understand that, for whatever reason, if I am uncomfortable about doing an exam prior to or during my office visit, I can suspend and reschedule the exam or a portion of the exam to a future date.

I understand that it is my right and my choice to have a chaperone or to refuse a chaperone in the room during my exam. A chaperone is a witness to any exam, usually of the same gender, and can be provided for your comfort.

I understand that the healthcare providers have offered a chaperone to be present and will provide a chaperone upon request. This request may be made at any time before or during this examination or any future examination.

Signing this form confirms that I understand all of the above facts and that they pertain to today's examination and future examinations.

The healthcare providers of SageMED want to be as thorough as possible, while respecting your feelings and privacy.

X_____ Date _____

Guardian: _____