REDWOOD THERAPY

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

In this document, "we" refers to Redwood Therapy, LLC. "You" or "yours" refers to individual patients. We are required by federal law to protect the privacy of your individual health information (referred to in this notice as "Protected Health Information" or PHI). We are also required to provide you with this notice regarding our legal duties and privacy practices with respect to your PHI, and to abide by the terms of this notice.

We maintain medical information about you in the course of providing health care services to you. We also hire business associates, such as a billing service and a transportation service, and bill third party payers, in the process of providing and billing these services. These business associates also receive and maintain medical information about you.

Purposes for which we may use or disclose medical information about you without your consent or authorization.

We may use and disclose medical information about you for the following purposes:

- **Health Care Providers' Treatment Purposes**. For example, to communicate with your doctor we may disclose medical information about you.
- **Payment**. For example, we may use or disclose medical information about you to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.
- **Health Care Operations**. For example, we may use or disclose medical information about you for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of contracts.
- **Health Services**. For example, we may use medical information about you to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **As Required By Law**. For example, we must allow the U.S. Department of Health and Human Services to audit our records. We may also disclose medical information about you as authorized by and to the extent necessary to comply with worker's compensation or other similar laws.
- **To Business Associates**. We may disclose medical information about you to business associates we hire to assist us in your care. Each business associate must agree in writing to ensure the continuing confidentiality and security of medical information about you.

We may also use and disclose medical information about you as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcements purposes.
- To your personal representatives appointed by you or designated by the applicable law.
- For research purposes, as long as certain privacy-related standards are satisfied.
- To a governmental agency authorized to oversee the health care system or government programs.
- We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care.

Authorizations: Uses and Disclosures with Your Permission

We will not use or disclose medical information about you for any other purposes unless you give us your written authorization to do so. If you give us written authorization to use or disclose medical information about you for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all medical information about you that we maintain, except for information we have already released based on your authorization.

Your Rights

You may make a written request to us to do one or more of the following concerning medical information about you:

- To put additional restrictions on our disclosure of medical information about you we do not have to agree to your request.
- To communicate with you in confidence about medical information about you by a different means or at a different location than we are currently doing you must do by a request in writing and must specify the alternative means or location.
- To see and get copies of medical information about you, we do not have to agree to you request.
- To amend medical information about you, in some cases we do not have to agree to your request.

Complaints

If you believe your privacy rights have been violated, you may notify us in writing or the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Conclusion

PHI use and disclosure by us is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in the Notice and the Privacy Standards.

If you have any questions regarding this notice or our health information privacy policies, please contact the office of Redwood Therapy at 602-628-0966 and speak to the Practice Administrator or billing department.

I hereby acknowledge that I have been provided and have reviewed Redwood Therapy's **Notice of Privacy Practice**.

REDWOOD THERAPY

FINANCIAL POLICIES AND PROCEDURES

We believe that all patients who seek the services of Redwood Therapy deserve the best care that can be provided. In order for us to provide you with the highest quality care and current technology, we must ensure that we are able to meet the expenses necessary for the success of our operation. To ensure that these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

PAYMENT AT THE TIME OF SERVICE: As a courtesy, we will bill your insurance for all therapy sessions and/or office visits. However, we ask that you pay any portion not covered by your insurance due to deductibles or co-payments on the day of service, unless otherwise specified in policies of Redwood Therapy, LLC.

SUBMISSION OF CLAIMS: We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

BALANCES DUE AFTER INSURANCE PAYS: If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. Payment arrangements can be made for special circumstances by contacting Redwood Therapy within 30 days of the receipt of the invoice. It is your responsibility to make contact with our office to make special arrangements.

DELIQUENT ACCOUNTS: We urge you to keep your account current to avoid any misunderstandings with our office. All account balances past due over 180 days will be sent to an outside agency for collections.. Contact our billing office at 602-628-0966, if temporary financial problems will affect timely payment of your account or if a payment plan is required to prevent your account from going to collections. Patient/Guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

PAYMENT ARRANGEMENTS: Under special circumstances, payment arrangements can be made. These arrangements are made with the Office Manager. Our office can set this up for you as a courtesy. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time of your payment arrangement is set up. After the second missed payment, the account will be sent to an outside agency for collections.

PAYMENT OPTIONS: Redwood Therapy accepts Visa, MasterCard, and American Express. Redwood Therapy also accepts checks or cash. There will be a fee assessment of at least $25 for all returned checks for non-sufficient funds, stop payments and account closures. Your account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for your account.

CASH PAYMENT: At times, you may have a co-pay or deductible that require payment at the time of service.

BILLING PROCEDURE: You will receive a statement with your remainder balance once a reply is received from your insurance company.

SELF PAY: If insurance does not cover your therapy and you are a self-paying, all payments will be due at the time services are rendered unless you have made prior arrangements with Redwood Therapy.

COMMUNICATIONS CONSENT: You agree, in order for us to service your account or to collect any amounts you may owe, that we, or any third-party vendor authorized by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, or any third-party vendor authorized by us, may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

x_____/_____/_____

Patient/Responsible Party Relationship to patient **Date**

REDWOOD
THERAPY

INFORMED CONSENT AGREEMENT

Thank you for choosing to use the services, or programs of Redwood Therapy. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, the undersigned, declare that I intend to use some or all of the therapies, activities, programs, and services offered by Redwood Therapy and I understand that each person, (myself included), has a different capacity for participation in such therapies, activities, programs, and services. I am aware that all therapies, activities, programs, and services, offered are therapeutic, educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or heath (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity, therapy, or program. I acknowledge that my choice to participate in any therapy, activity, programs, and services of Redwood Therapy brings with it my assumption of those risks or results stemming from this choice and the fitness, health, and awareness, care, and skill that I posses and use.

I further understand that personnel, who may not be licensed, certified, or registered instructors or professionals sometimes conduct the therapies, activities, programs, and services offered by Redwood Therapy. I accept that fact that the skills and competencies of some employees will vary according to their training and experience and that no claim is made to offered assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certifier, or registered and herein employed to provide such professional services.

I recognize that by participating in the therapies, activities, programs, and services offered by Redwood Therapy, that I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions or request further explanation or information about the therapies, activities, programs, and services offered by Redwood Therapyat any time before, during, or after my participation.

I declare that I have read, understood and agree to the contents of this informed consent agreement in its entirety.

x_____/_____/_____

Patient/Responsible Party Relationship to patient **Date**