RELEASE AGREEMENT

THIS RELEASE AGREEMENT ("Agreement") is made, entered into, and effective as of the date set forth below between the undersigned client ("Client") and Jeffrey N De Wester Treatment & Research Center (DTRC) from here on, in this release, to be known as "DTRC". The release is solely intended to release DTRC of any and all liability in relation to the client's service / treatment during the COVID-19 outbreak.

Client / Patient agrees that by having this service / treatment, despite the preventative measures that have been undertaken by DTRC to make the service as safe as possible, 100% safety may, or may not, be possible relative to the possible contraction of COVID-19.

Client understands that although none of the attending DTRC staff have been diagnosed with, or have any symptoms of COVID-19, there is still some potential virus contraction risk associated with their service / treatment during the current outbreak. Additionally, client confirms that they have not been diagnosed with, nor have the symptoms of, COVID-19.

Client also agrees that they have not been in contact with anyone, to their knowledge, that has the symptoms of, or has been diagnosed with, COVID-19 within the last 20 days.

This release agreement is relative to this service / treatment and all future services / treatments during the COVID-19 outbreak.

Client agrees that by signing this release agreement they hereby release DTRC of any current or future liability they may, or may not have, as a result of doing the service.

Client Name: _____

Client Signature: _____

Date: _____

Jeffrey N De Wester Treatment and Research Center, LLC "DTRC"

By: _____

Its: _____

IMPROTANT IMFORMATION FOR ALL PATIENTS!

1. APPOINTMENTS:
   - We will attempt to call you the day before your scheduled appointment. There are times however, when we are unable to make reminder calls. Ultimately, it is your responsibility to know when your appointments are scheduled.
   - We now require that you call **one business** day prior to your scheduled appointment if you need to cancel. This allows time to schedule other patients who need to be seen. This policy is necessary in order to free unused appointment times for other patients. Patients who don't call to cancel will be charged a fee proportional to the length / type of appointment. (Non- business days are Wednesdays, Saturdays and Sundays)
   - Due to the number of patients seen each day, WE ARE UNABLE TO SEE PATIENTS WITHOUT AN APPOINTMENT. If you feel you need to see a doctor immediately, please CALL our office before coming in. We will make every effort to schedule you to be seen the same day. If no appointments are available, your doctor will notify you as soon as possible with instructions.
   - If you have an emergency, please go to a facility equipped to handle emergency situations.

   Please keep in mind that there is more involved in seeing a doctor than just "seeing the doctor". Appointments are necessary to insure that every patient who needs to be seen CAN be seen in a timely manner. Remember, if you demand to be seen without an appointment, you make someone else wait past his/her appointment time. Please call before coming in!

2. Prescription refills and/or samples:
   - We are now required by law to send your pellets to your home prior to your appointment please make sure to bring them with you to your appointment if you forget them we will not have supplies on hand. If you need to return home to get them we may require you to reschedule your appointment depending on the patient load that day.
   - We now require 72 hours to fill your prescription and/or sample request. We will no longer call to confirm that you prescriptions have been called in. You will need to call your pharmacy for confirmation.
   - No pain, nerve or sleeping medications will be called in after hours or on weekends, nor will they be called in by a doctor other than the one who originally prescribed them.
   - If you are written a Controlled substance prescription please take special care of it and the medication , if script or medication is lost another script will not be written until the previous script date as expired (this is do to the new federal laws)

- Routine prescriptions are filled during business hours with the exception of surgery day (Non hormone scripts will not be written). The information listed below is required to be left on our prescription phone line in order to process your refill request within 72 hours:

    - Patient's Name, Date of Birth & Phone Number
    - Name of Medication (Spelling), Dosage, & Direction
    - Prescription Number on bottle
    - Pharmacy Phone Number
    - Doctor (s) Name
    - Next Appointment Date

- If you have not been seen by your doctor within the last 6 months, an office visit will be required before a routine refill can be called to a pharmacy.
- If you request to be put back on a medication you haven't taken or the doctor stopped in the past this will require a office visit or teleconference please do not request this on the script line. Please call the office to set up an appointment.
- Office visit or Teleconference is required before new medications can be prescribed for new illnesses'. There will be a *$15.00 fee* for any refills written without a routine or medication office visit. Be sure to ask for any refills at the time of your appointments when being seen by the doctor, (Reminder non-hormonal scripts will not be written on Pellet surgery days).

3. INSURANCE:

    ❖ We do not accept insurance

    You will be responsible for all portions of balance at the time of service

4. MEDICAL RECORDS:
    - If copies of your medical records are required for an appointment with a specialist, we will copy those records; however, you will need to pick them up from our office and take them with you to your appointment. We will no longer fax these records to the specialist. Please check with the specialist's office in advance of your appointment to see if any records or test results will be needed. Please request copies at least 2 days prior to your appointment. Please be aware that if multiple requests are made a fee may be associated with it, if the request is for yourself a fee may apply. Please make sure to ask the front desk prior to having making the request.

Jeffrey N De Wester Treatment and Research Center

6447 South East Street Suite D
Indianapolis, IN 46227
463-206-2166
Fax (317)735-1951

Acknowledgement of Prescription refills and/ or Samples Protocol

Prescription are written at non-surgical appointments, please advise the Nurse if you need refills and if you are in need of, 30 day or 90 day scripts.

- Any type of controlled substance (i.e. Pain, Sleeping, ED, etc.) will not be called in after hours or on weekends.
- If you have not been seen by the doctor within the last 6 months, an office visit will need to be scheduled before a refill can be called to a pharmacy. (if the scheduled appointment is not kept no further refills will be called in or written until you have been seen by the doctor.
- If seen within the last six months have a follow-up visit schedules, but your medication will run out before this visit, refills will be provided in the amount needed to cover you until your office visit.
- Office visit or Teleconference is required before new medications can be prescribed for "new illnesses' or an illness that a script has not been written for in this calendar year.
- There will be a *$15.00 fee* for any refills written without a routine or medication office visit.
- We do not accept phone calls or faxes from pharmacies for script refills.
- We require 72 hours to fill your prescription and/or sample request. We will no longer call to confirm that your prescriptions have been called in. You will need to call your pharmacy for confirmation.
    - Please do not stop by the Nurses station when you are in for your lab appointment.
    - Please do not drop by the office to request refills please call the script line at 463-206-2166 option 2. The information listed below is required to be left on our prescription phone line in order to process your refill request within 72 hours or less:

        - Patient's Name, Date of Birth & Phone Number
        - Name of Medication (Spelling), Dosage, & Direction
        - Prescription Number on bottle
        - Pharmacy Phone Number
        - Doctor (s) Name
        - Next Appointment Date
        - Indicate 30-day or 90 day

_____ _____

Patients Signature Date

Jeffrey N De Wester
Treatment and Research Center
"Fee for Service Provider"
Jeffery N. De Wester, MD

WELCOME TO OUR PRACTICE!

Welcome to the offices of Dr. Jeffrey N. De Wester. Our office is located at 6447 S. East Street Suite D, just south of 465, at the corner of Banta Avenue & East Street (US 31)Office complex is called Banta Trails, on the East side of the street (Forrest Dentistry is also located in the same building).

Please fill out the enclosed forms completely, & return to our office at least two days prior to your appointment (**Note: *Please make sure the patient history form is filled out completely, if not we will not be able to see you until it is completed***). Also enclosed you will find information on our office policies and procedures. Please read over the enclosed information and let us know if you have any questions.

Upon arrival for your first appointment, please check in at our front office. We will need to copy driver's license so please bring them with you. We don't accept insurance so you will be required to make payment in full at the time service. If you are unable to keep a scheduled appointment, we ask that you call a week before to cancel that appointment as a large amount of time will be blocked out(3-4 hrs) this will allow us time to offer those times to other patients in need. If you cancel later than this we will charge you for the office visit in the amount of $250.00 a credit card will be requested upon scheduling and will ONLY be charged if you cancel or NO Show.

****Please bring with you or have your doctor (s) fax to JNDTRC before your appointment the results of any past cardiac (heart) testing or other testing listed below; If you come to your new patient appointment without them you will be requested to reschedule your appointment and will be charged for that office visit day.**

Examples:

- **Echocardiogram**
- **Stress Testing**
- **Cardiac Catheterization**
- **Heart Scan "Coronary calcium CT Scan**
- **Carotid ultrasound**
- **Any cardiac screening performed at a health fair**

- **PAP**
- **Mammogram**
- **Biopsy**
- **BMD(Bone Density)**
- **MRI's**
- **Sleep Study**

We look forward to serving you. If you have any questions please feel free to contact us at 463-206-2166 option 1. ,Fax 317-735-1951

Thank you.

Jeffrey N De Wester
Treatment and Research Center
Jeffery N. De Wester, MD

Jeffrey N De Wester Treatment &Research Center, LLC

2020 PATIENT INFORMATION SHEET
PLEASE PRINT

HOME PHONE_____ CELL PHONE_____

PATIENT INFORMATION
THIS FORM MUST BE COMPLETELY FILLED OUT

NAME_____ SOC SEC#_____
(LAST) (FIRST) (MI)

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

EMAIL _____

Do you wish to have appointment reminders sent to you VIA test message (standard test messaging rates apply) Y / N

Gender ( )M ( )F AGE____BIRTHDAY_____( )SINGLE ( )MARRIED ( )WIDOWED ( )SEPERATED ( ) DIVORCED

PATIENT EMPLOYED BY_____ OCCUPATION_____

BUSINESS ADDRESS_____ BUSINESS PHONE_____

INCASE OF EMERGENCY WHO SHOULD WE NOTIFY?_____ PHONE_____

PRIMARY CARE PHYSICIAN

PHYSICIANS NAME_____

ADDRESS_____CITY _____STATE ___ ZIP CODE _____

PHONE: _____

Insurance is not accepted: If you wish, may file with your insurance company for out of network coverage.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES,

_____ _____ _____
(RESPONSIBLE PARTY'S SIGNATURE) (RELATIONSHIP) (DATE)

Jeffrey N. De Wester Treatment and Research Center, LLC

Patients Name: _____ Account#_____

Jeffrey N. De Wester Treatment and Research Center, LLC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE

By signing this authorization, I authorize JNDTRC, LLC to use and/or disclose certain protected health information (PHI) about me to:

Name: _____ Relationship: _____

Address: _____

Phone #_____Fax#_____

This authorization permits Jeffrey N. De Wester Treatment and Research Center, LLC to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc. or specify any/all information requested by the party above):

_____

_____

This information will be used or disclosed for the following purpose:

_____

_____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire when revoked in writing.

The Practice will ☐ will not ☒ receive payment or other reimbursement from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Jeffrey N. De Wester Treatment and Research Center, LLC. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the:

Privacy Officer
Jeffrey N. De Wester Treatment and Research Center, LLC
6447 S. East Street Suite C /D
Indianapolis IN 46227

Signed by: _____ _____

Signature of Patient of Legal Guardian — Relationship to Patient

_____ _____

Print Name of Patient or Legal Guardian — Date

_____ _____

Witness Signature — Print Witness Signature

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION
I reaffirm this authorization:

Date: _____Initials: _____
Date: _____Initials: _____
Date: _____Initials: _____
Date: _____Initials: _____
Date: _____Initials: _____
Date: _____Initials: _____

Date: _____Initials: _____
Date: _____Initials: _____
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Date: _____Initials: _____
Date: _____Initials: _____
Date: _____Initials: _____

Jeffrey N De Wester Treatment and Research Center

6447 South East Street Suite D
Indianapolis, IN 46227
463-206-2166
Fax (317)735-1951

Phone Consultation Informed Consent Form

I _____ , have request to have phone consultations with Dr. Jeffrey N De Wester for those visits where it is deemed medically appropriate. I understand that these will be paid for by cash basis. I accept full financial responsibility to pay the fees incurred for such telephone consultations.

Signature _____ Date: _____

Jeffrey N De Wester Treatment and Research Center

6447 South East Street Suite D
Indianapolis, IN 46227
463-206-2166
Fax (317)735-1951

In order to provide maximum service to our patients, we need to contact you at home.

To insure confidentiality, please indicate how you want to be contacted.

_____ Please call me at this number _____

_____ I DO NOT want a message left: therefore please follow these arrangements to contact me:

_____

_____

_____

Signature _____ Date: _____

Account Number: _____

Jeffrey N De Wester Treatment & Research Center, LLC

6447 South East Street Suite D
Indianapolis, IN 46227
463-206-2166

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I,_____, have received a copy of Jeffrey N De Wester Treatment and Research Center, LLC (JNDTRC) Notice of Privacy Practices.

_____ _____

Signature of Patient Date

_____ _____

Witness Signature Date

Effective Date: 03/1/2017

Jeffrey N De Wester Treatment and Research Center, LLC

463-206-2166, 6447 S. East Street Indianapolis IN 46227.

The HIPAA privacy rule requires all covered entities to make available a Notice of Privacy Practices to all individuals who receive or use their services. Following is a model notice that can be used as the starting point for a covered entity to develop its own specific Notice of Privacy Practices. It includes the elements of the notice's content that are required by §164.520. However, each covered entity should modify these provisions to reflect its own individual privacy practices. In addition, health plans have special provisions that must be included regarding the prohibition on the use of genetic information for underwriting purposes. All covered entities need to make the notice available upon request in paper form. A copy or a summary of the notice (see sample in the August issue of RPP) needs to be displayed prominently in the patient area of the clinical facilities. If a summary notice is provided, copies of the full notice must be readily available (e.g., in a box next to the summary notice). If the covered entity maintains a website, the notice needs to be available on the website and easy for anyone to locate and access from the website. Direct care providers need to give a Notice of Privacy Practices to any new patient at the time of first encounter and request that patients to sign an acknowledgement of receipt at that time. If a patient refuses to sign the acknowledgement, the provider should note this in the medical record. Direct care providers cannot provide a summary notice at first encounter nor can they provide the notice only if a new patient asks for it. NOTE WELL: The new provisions required by the HIPAA/HITECH omnibus rule appear below in italics.

NOTICE OF PRIVACY PRACTICES

Effective Date: 03/1/2017

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.

If you have any questions about this notice, please contact a staff member of Jeffrey N De Wester Treatment and Research Center, LLC at 463-206-2166, 6447 S. East Street Indianapolis IN 46227.

WHO WILL FOLLOW THIS NOTICE This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Jeffrey N De Wester Treatment and Research Center, LLC. Your health information may include information created and received by Jeffrey N De Wester Treatment and Research Center, LLC may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

Effective Date: 03/1/2017

Jeffrey N De Wester Treatment and Research Center, LLC

463-206-2166, 6447 S. East Street Indianapolis IN 46227.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

• **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart Sample Notice of Privacy Practices This sample Notice of Privacy Practices (NPP) was developed by HIPAA consultant Chris Apgar of Apgar and Associates in Portland, Ore. It incorporates new 2 Report on Patient Privacy August 2013 condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our organization may share information about you and disclose information to people who do not work for [Covered Entity Name] in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

• **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at Jeffrey N De Wester Treatment & Research Center, LLC may be billed to and payment may be collected from you • For Health Care Operations. We may use and disclose health information about you in order to run Jeffrey N De Wester Treatment & Research Center, LLC and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

[If patients may be contacted for fund raising purposes]

• **For Fund Raising**. We may contact you to ask for your help with different fund raising campaigns. Please notify us if you do not wish to be contacted during fund raising campaigns. If you advise us in writing (at the physical or email address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

• **To Avert a Serious Threat to Health or Safety**.

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• **Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.

• **Research**. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

• **Organ and Tissue Donation**. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

• **Military, Veterans, National Security and Intelligence**. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

• **Workers' Compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **Public Health Risks**. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

• **Health Oversight Activities**. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Jeffrey N De Wester Treatment and Research Center, LLC

463-206-2166, 6447 S. East Street Indianapolis IN 46227.

• **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

• **Law Enforcement**. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar August 2013 Report on Patient Privacy 3 process, subject to all applicable legal requirements.

• **Coroners, Medical Examiners and Funeral Directors**. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

• **Information Not Personally Identifiable**. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

• **Family and Friends**. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel. We also will not use or disclose your health information for the following purposes without your specific, written Authorization: [Include the following if applicable]

• **For our marketing purposes**. This does not including face-to-face communication about products or services that may be of benefit to you and about prescriptions you have already been prescribed.

• **For the purpose of selling your health information**. We may receive payment for sharing your information for, as an example, public health purposes, research, and releases to you or others you authorize a release to as long as payment is reasonable and related to the cost of providing your health information.

Jeffrey N De Wester Treatment and Research Center, LLC

463-206-2166, 6447 S. East Street Indianapolis IN 46227.

• **Any disclosure of your psychotherapy notes**. These are the notes that your behavioral health provider maintains that record your appointments with your provider and are not stored with your medical record.

If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, **in writing**, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as psychotherapy notes, HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a 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 disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU You have the following rights regarding health information we maintain about you:

• **Right to Inspect and Copy**. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Jeffrey N De Wester Treatment & Research Center, LLC in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record. If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit continued 4 Report on Patient Privacy August 2013 your request in writing to Jeffrey N De Wester Treatment & Research Center, LLC . You have the right to request a copy of your health information in electronic form if we store your health information electronically. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Jeffrey N De Wester Treatment and Research Center, LLC

463-206-2166, 6447 S. East Street Indianapolis IN 46227.

• **Right to Amend. If you believe health information we have about you is incorrect or incomplete,** you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Jeffrey N De Wester Treatment & Research Center, LLC . To request an amendment, complete and submit a medical record amendment/correction form to Jeffrey N De Wester Treatment & Research Center, LLC We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be (number) of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

• **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement. To obtain this list, you must submit your request in writing to [designated privacy official/contact person]. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

Effective Date: 03/1/2017

Jeffrey N De Wester Treatment and Research Center, LLC

463-206-2166, 6447 S. East Street Indianapolis IN 46227.

We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to [designated privacy official/contact person].

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction On Use/Disclosure Of Medical Information and/or Confidential Communication to Jeffrey N De Wester Treatment & Research Center, LLC . We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

• **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Jeffrey N De Wester Treatment & Research Center, LLC

CHANGES TO THIS NOTICE We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. {If a direct care provider - We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

BREACH OF HEALTH INFORMATION We will inform you if there is a breach of your unsecured health information.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at: Office for Civil Rights Region U.S. Department of Health & Human Services] To file a complaint with Jeffrey N De Wester Treatment & Research Center, LLC , contact Jeffrey N De Wester Treatment & Research Center, LLC , attn.: Office Manager, office responsible for handling complaints listed on the first page as the contact for more information about this notice.. **You will not be penalized for filing a complaint**.

Jeffrey N De Wester Treatment and Research Center

6447 South East Street Suite D
Indianapolis, IN 46227
463-206-2166
Fax (317)735-1951

Non- Insurance Provider

The Jeffrey N, De Wester Treatment and Research Center does not accept insurance, all services rendered will be on a cash bases and shall be paid at the time of service. These treatment are experimental and investigational. As your physicians, we believe that these procedures are in your best medical interest, or we would not be ordering them. We believe that these are "medically necessary".

Because the Jeffrey N. De Wester Treatment and Research Center does not accept insurance we ask our patients to sign the waiver below, which states you have been informed that we do not accept insurance and you will be paying cash

Financial Responsibility:

The undersigned accepts full responsibility for the payment of charges at the time of services unless other agreements were made with the office manager prior to your visit.

The undersigned assumes and agrees to pay for all collection agency fees paid or incurred by us for the collection of the undersigned patient's debt. The undersigned agrees to pay reasonable attorney fees, court fee, and other fees paid to incurred by this office or our collection agency while collection the amount due.

I understand that I am financially responsible for all charges.

This authorization is in effect until rescinded.

Signature _____ Date: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Jeffrey N De Wester Treatment and Research Center, LLC, as well as all employees, employers, representatives, and agents thereof; as well as all laboratories, pharmacies, clinics, hospitals, and equipment suppliers used by or referred by Healthcare Provider (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, equipment, tests, treatments, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. It is also my intention that Healthcare Provider shall possess any and all anti-retaliation protections that I may have under 29 U.S.C. § 1140 whenever Healthcare Provider is exercising my rights or acting on my behalf, or as my assignee, in anyway whatsoever.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing, and in such case, can only be revoked for future services, test, etc. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____ (SEAL)
(patient signature)

_____
(please print patient name)

X_____ (SEAL)
(signature of Guardian if applicable)