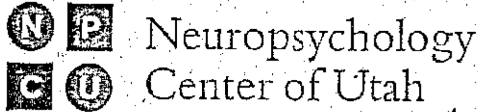
ATTENTION!

PAPERWORK MUST BE COMPLETELY FILLED OUT BEFORE YOU COME TO YOUR APPOINTMENT. IF PAPERWORK IS INCOMPLETE WHEN YOU SHOW UP, YOU WILL NOT BE SEEN AND WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.

PLEASE NO CHILDREN UNDER 18 TO YOUR FIRST INITIAL APPOINTMENT.

PLEASE BRING COMPLETED PAPERWORK TO YOUR FIRST APPOINTMENT. IF YOU WOULD LIKE TO SEND US YOUR PAPERWORK BACK BEFOREHAND, YOU CAN DO SO 3 DIFFERENT WAYS:

1. EMAIL: NPCU@NPCU.NET
2. FAX: 801-825-1162
3. MAIL: 1407 N 2000 W SUITE A
   CLINTON, UT 84015



1407 North 2000 West, Suite A
Clinton, Utah 84015
Phone: (801) 614-5866
Fax: (801) 825-1162

Last Name:	First:	MI:
Address:	City:	State: Zip:
Home PH#:	Cell PH#	Preferred Contact (Circle one) Home Cell Work Email
Social Security #	Date of Birth:	
Email (If you would like reminder emails for appointments):		
Sex: M F	Race: □ American Indian □ Asian □ African American □ Pacific Islander □ White □ Other	Ethnicity: □ Hispanic □ Non-Hispanic
Patients Employer (If applicable):	PH#:	
Spouse (If applicable):	PH#	Employer
Emergency Contact:	PH#	Relation:

INSURANCE INFORMATION

PLEASE LIST ALL HEALTHCARE INSURANCE COMPANIES WHICH COVER THE PATIENT.
INSURANCE INFORMATION MUST BE FILLED OUT COMPLETELY IN ORDER TO PROCESS YOUR CLAIM.

Primary Insurance Co:	Group #:	Policy #:		
Address:	City:	St:	Zip:	PH#:
Subscriber:	DOB:	SS#	Relation:	
Secondary Insurance Co:	Group #:	Policy #:		
Address:	City:	St:	Zip:	PH#:
Subscriber:	DOB:	SS#:	Relation:	
Who is your Primary Care Physician?				

RESPONSIBLE PARTY

THIS IS THE PERSON FILLING OUT THIS FORM

Last name:	First:	PH#	
SS #:	DOB:	Relation to Patient:	
Address:	City:	State:	Zip:
Employer:	PH#		

PLEASE READ AND SIGN THE FOLLOWING

***Remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, Others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurances or any other balance not paid by your insurance. The above information is for the purpose of obtaining credit and is warranted to be true. You have the right to request a copy of your records. You may also request an amendment of those records in writing.

I authorize the Neuropsychology Center of Utah and/or its agents and assigns to make credit investigations, including employment verification. I authorize treatment of the person named above and agree to all charges for such treatment. I agree to pay all charges for myself and members of my family shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing as is more fully set forth below. It is the policy of the Neuropsychology Center of Utah to only release health and personal information as is needed for payment of claim or as necessary for direct patient care to other providers or health care entities. I directly assign all medical/surgical benefits to the Neuropsychology Center of Utah and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I agree that if this account goes into default and legal action is taken, I will be responsible for all legal and court costs incurred. I understand that payment for the service provided to me is due and owing at the time service is rendered. Unless other specific arrangements are made. Which arrangements should be set forth in writing and be attached to this information sheet. I agree that if the account goes into default and payment is not made, I shall be responsible to pay any and all attorney fees, court costs, and/or other charges, together with an additional 25% collection fee and interest rate of one and one half (1.5%) per annual on any unpaid balance.

Sign (Patient or Guardian if Minor):	Date:

Neuropsychology
Center of Utah

BILLING INFORMATION

You must call your insurance company prior to your first appointment!!

Mental Health Insurance benefits differ from medical benefits. It is **YOUR Responsibility** to call your insurance company and understand your coverage and benefits. Most patients are required to pay at least a portion of the expenses accrued at our office.

When you call your insurance company you should ask them a number of questions. First, make sure Adam Schwebach, Ph.D. is a provider on your plan. In some cases you may be seeing Dr. Schwebach's resident/intern. Services provided by the resident/intern are billed under Dr. Schwebach's Tax ID # and name.

Secondly, you should ask your insurance company about your specific coverage and whether you have a co-payment, co-insurance or deductible. To assist you in this process, it is helpful to know the "procedure" or "CPT Codes" we use to bill your insurance.

- There are a number of Codes that are used for billing. For your reference, we have attached the sheet of all the billing codes. **We have BOLDED the most commonly used codes.** BUT, every patient is different and the exact codes will not be known until you come in for your initial intake appointment. We recommend checking all codes.

Please Make Note:

NPCU DOES NOT ACCEPT PAYMENT PLANS.

All co-pays, co-insurance and deductibles **MUST** be paid in full at the time of service. The patient and/or responsible party is required to understand insurance coverage and benefits. Patients who have deductibles and or co-insurance plans will be asked to pay a "deposit" at the time of service. The deposit for therapy appointments is $100 . Patients who do not make payments at the time of service will be charged an additional surcharge and **WILL NOT** be seen. **We will not schedule any future appointments if you have a balance due on your account.** If you have additional billing questions, please contact our office.

By signing below, I have read and agreed to all the above information.

Responsible Party

Date

Neuropsychology
Center of Utah

BILLING CODES

First Initial Intake Appointment:

- **90791** Initial Diagnostic Interview

Therapy Codes

- 90832 20-30 Minute Therapy Visit
- **90834** 40-50 Minute Therapy Visit
- **90837** 50-60 Minute Therapy Visit

Testing Codes

- **96130** Psychological Testing (First Hour)
- **96131** Psychological Testing (Each Additional Hour, Add On Code)

- 96132 Neuropsychological Testing (First Hour)
- 96133 Neuropsychological Testing (Each Additional Hour, Add On Code)

- **96136** Testing Administration (First 30 Minutes)
- **96137** Testing Administration (Each Additional 30 Minutes, Add On Code)

- 96138 Testing Administration by Technician (First 30 Minutes)
- 96139 Testing Administration by Technician (Each Additional 30 Minutes, Add On Code)

- 96146 Computerized Testing

***For the self-pay rate for testing, it will be roughly around** $1,075.00
This amount needs to be paid at the time of the appointment.

Neuropsychology
Center of Utah

BILLING POLICY

The Patient, **NOT** the insurance company, is ultimately responsible for any outstanding balances.

NPCU does not accept payment plans. Patients are required to pay any outstanding balances, co-pays, deductibles and or co-insurances at the time of service. **Patients who do not pay their co-pay or outstanding balances at the time of service will be charged an additional surcharge and interest and WILL NOT be seen by their provider.**

If a balance is sent to collections, an additional 33% surcharge will be added to the total account balance.

Initial and sign below:

__________ **Patients with co-insurance or deductibles will be asked to make a "deposit" at the time of service. The deposit for therapy appointments is $100 . For evaluations.**

__________ **EVALUATIONS: When billing for an evaluation, patients will be charged for both the "face to face" time spent with the examiner AND for the time it takes to score the tests, interpret test results and write a report. A typical evaluation is billed for approximately 8 – 10 hours of time.**

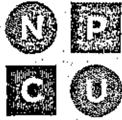
__________ **I understand that if I do not pay my co-payment, co-insurance, deductible or any outstanding balance at the time of my appointment, NPCU will charge me an additional surcharge AND I WILL NOT be seen by the provider. I will be responsible to pay any and all additional surcharges and interest.**

__________ **I understand NPCU does not accept payment plans.**

By signing below, I agree to the NPCU Billing Policy

____

Responsible Party Date



Neuropsychology
Center of Utah

LATE CANCELLATION & NO SHOW POLICY

NPCU requires 24 hour notice for cancellation of appointments

If you do not call within **24 hours** to cancel your appointment, a "No Show/Late Cancellation" fee will be charged to your account. Late cancellation and or no show charges cannot be billed to your insurance. The patient and/or responsible party will be required to pay the full amount if the appointment is missed.

Initial and Sign Below:

________ I have read and understand the NPCU Late Cancellation and No Show Policy.

________ I understand if I do not show up or cancel my appointment within 24 hours for a scheduled **THERAPY** appointment I will be charged a $25.00 fee. I understand that if I am **more than 20 minutes late** to my scheduled therapy appointment, **I will not** be seen and will be charged a $25.00 fee.

________ I understand if I do not show up or cancel my appointment for a scheduled **EVALUATION** I will be charged a $250.00 fee.

________ I understand that this fee **CANNOT** be billed to my insurance and I will be solely responsible to pay this fee.

________ I understand that if I **NO SHOW** for two consecutive appointments, NPCU will cancel all of my remaining appointments.

By signing, I have read and understand the NPCU Cancellation Policy.

____

Responsible Party Signature Date

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

A. The term "We", "parties" or "us" means you, (the Patient), and the Provider.

B. The Term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" mean the physician, group or clinic and their employees, partners, associates, agents. Successors and estates.

D. The term "Patient" or "you" means:

(1) You and any person who makes a Claim for care given YOU, such as your heirs, your spouse, children, parents or legal representatives, AND

(2) Your unborn child or newborn child for care provided during the 12 months immediately following the date you signed this Agreement, or any person who makes a Claim for care given to the unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:

(1) Working directly with each other to try and find a solution that resolves the Claim, OR

(2) Using non-binding mediation (each of us will bear one-half of the costs); OR

(3) Using binding arbitration as described in this Agreement. You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration - Final Resolution. If working with the Provider or using non-Binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice'). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.

B. Arbitrators. Within 30-days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly Selected Arbitrator") If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly- Selected Arbitrator from a list of individual approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly- Selected Arbitrator, each or both of us may request that the Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one – half of the fees and expenses of the Jointly Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision (Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A Joined Party does not participate in the selection of the arbitration but is considered a Provider for all other purposes of this agreement.

Article 5 Liability and Damages May be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the jointly selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue/Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fall to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities or parties to the arbitrations.

Article 7 Terms / Rescission / Termination

A Term. This agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this agreement within 10-days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this agreement will govern all medical services received by the patient from provider after the date of signing, except in the case of joined party that provided care prior to the signing of this agreement (see article 4).

C. Termination. If the agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the agreement. To terminate this agreement, send written notice by registered or certified mail to the provider. This agreement applies to any claim that arises while it is in effect, even if you file a claim or request arbitration after the agreement has been terminated.

Article 8 Severability

If any part of this agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this agreement. I have had the right to ask questions and have my questions answered. I understand that nay claim I might have must be resolved through the dispute resolution process in this agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration costs. I understand that this agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the agreement and still receive health care. I understand that I can rescind this agreement within 10-days of signing it.

Article 10 Receipt of copy I have received a copy of this document.

Neuropsychology Center of Utah

________________________ ________________________

Name of Physician, Group or Clinic | Name of Patient (Please Print)

By: ________________________ ________________________

Signature of Physician or Authorized Agent | Signature of Patient or Patient's Representative | Date

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

Notice of Privacy Policy
Effective September 1, 2010

The following is the privacy policy of The Neuropsychology Center of Utah ("Covered "Entity") as described in the Health Insurance Probability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPPA. HIPPA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number and others that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still able to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or

healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement , you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Neuropsychology Center of Utah 1477 N 2000 W Clinton, Utah 84015.

Tight To Receive An Accounting OF Disclosures OF Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six(6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information. *We are not required to provide accountings of disclosures for the following purposes:* (A) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests shall be sent to the Neuropsychology Center of Utah 1477 N 2000 W Clinton, Utah 84015.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, at the Neuropsychology Center of Utah 1477 N 2000 W Clinton, Utah 84015. Phone number 801-614-5866

A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this privacy policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy notice, by email or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to the Neuropsychology Center of Utah 1407 N. 2000 W. Clinton, Utah 84015. Phone (801)614-5866.

For any other requests or further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer at the address or telephone number listed above.

NEUROPSYCHOLOGY CENTER OF UTAH

ACKNOWLEDGMENT OF PRIVACY NOTICE

I have received a notice of the privacy policy for NPCU. I have been given the opportunity to read and ask any questions I may have. I understand how and why my personal information may be used.

________________________________ ____________________

Signature of Patient or Guardian Date