Biofeedback Patient Information Form

Patient Name: (Last)_____(First)_____(MI)_____

Name you prefer to be called: _____

Patient Address for shipping: (No PO Boxes)_____

City: _____ State: _____ Zip: _____

Home Phone: _____Beeper/Cellular: _____ E-mail Address_____

Birthdate: _____Social Security: _____Age: _____ Sex: M F

How did you hear about us? (circle) Sign Paper (which one)_____Event (which one)_____

Magazine (which one)_____ Referral (from whom)_____Internet Other (where)_____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

In Case of Emergency:

Name: _____Relationship: _____ Phone:_____

Patient's Spouse: _____Phone: _____

Family Physician: _____Phone: _____Referred by: _____

Insurance Information:

Name of Carrier:_____ Policy Number:_____

Customer Service Number:_____ Internal Use:_____

Please provide the front desk attendant with a copy of your insurance card and drivers license!

Financial Policy:

Thank you for selecting Atlanta Medical Institute, LLC for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and checks. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Signature: _____ Date: _____

Number of organs removed? (Two of 1 kind = 1)		Amount of fat in diet, as percentage including processed foods (scale 1-10)	
Number of prescription drugs used currently		Number of sugar type products daily including soft drinks, ice cream, cookies, etc.	
Amount of time you smoke daily (number of cigarettes, cigars, etc.)		Number of exercise sessions per week 20 minutes or more- not work based	
Number of steroid-type drugs used in the last year		Number of alcoholic drinks daily. On average	
Number of amalgam and/or metal fillings currently, or present during last year		Number of cups of coffee, tea, soda, or any caffeine products daily	
Number of street drugs used last month		Number of extreme toxic exposures this year, inc. radiation, insecticide, chemicals	
Number of unresolved mental factors		Number of major past & present, including emotional or physical traumas	
Responsibility for your body/disease (0=min/10=max)		Number of glasses of water or natural fruit juice per day	
Personal Stress 0-10 If your answer on Personal Stress is 7 or above, please answer the following questions below, with the same scale. (**10 being the highest**)		How many kilos overweight 2.2 lbs = 1 kilo	
___Interpersonal Stress (between you and others? ____ Job or school related ___ Struggle-with self ___ Stress from sickness Stress from family ___Stress from desire for		things to be different ____Physical stress or imbalance ___digestive stress ____imbalance with sweating ___Urination ____Mucous (excessive) ____Menses ____Breath ____Skin ____Insomnia	

If Bolded, do not use Electromedicine Modalities (CES, Probes)
___Seizures ___Stroke

If Bolded, do not use any Electromedicine devices or biofeedback (May use Photon stimulator)
___Currently pregnant ___Pacemaker or Defibrillator ___Implants for pain

Do you have any of the following today?
___Sunburn ___Pregnancy ___Headache ___Pain ___Irritated skin rash

The registered SCIO software and hardware uses a micro current medically safe pulse applied to the wrists, ankles and forehead. We safely measure some of the electrical aspects of the body. A variant micro current is then adapted to the patient to feedback the signal. The Clasp 32 software will use the same medically safe standards to develop to develop a wider range of variant wave forms to measure the body's reactivities. **There is insignificant risk and the only discomfort is in sitting still for the session.**

Neither biofeedback professionals nor biofeedback devices are intended to diagnose, treat, cure, or prevent any medical or psychological conditions, disease, or disorder. I am not a medical doctor, DC, or psychotherapist. I am a biofeedback professional and practice biofeedback training according to the laws of the state of which I am practicing. I train people with biofeedback to manage their stress and pain through relaxation and to become aware of lifestyle changes to enhance a positive state of health.

I promise to immediately inform Atlanta Medical Institute if I am a government official or if I represent or am affiliated with a news media company or corporation. My permission to receive a session is totally contingent upon such disclosure and my refusing or neglecting to so would constitute a fraudulent deception on my part.

Signature_____ Date_____

Biofeedback Consultation Waiver

I fully inderstand that the attending therapists are not allopathic doctors (MD's), but are nutritional, wellness consultants and are biofeedback specialists.

I fully understand the difference between the practice of allopathic medicine, nutritional wellness consulting, and Biofeedback.

I fully understand that the services provided by the attending therapists are not allopathic, but are nutritional, behavioral, or biofeedback in nature.

I fully understand that the attending therapists perform their services within the parameters of a natural health care and wellness system using Biofeedback and Stress Reduction.

I fully understand that the attending therapists do not offer allopathic drugs, surgery, chemical stimulants or radiation therapy. I understand that illness is not being diagnosed nor treated and that my wellness and stress are being measured.

I have solicited the attending biofeedback therapists' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.

If I desire any services not provided by the attending Biofeedback therapists, which is my prerogative, I fully understand that I could seek them elsewhere.

I presently seek counsel, advice, opinions, Biofeedback, or points of view and/or programs within the scope of the attending therapists' wellness and stress reduction practice.

I fully understand that the services provided by the attending therapists are not generally accepted and/or recommended by allopathic doctors or other conventional health professionals.

I hereby release the Biofeedback specialist to do Biofeedback tests and treatment.

This request for information does not imply, in any way, the practice of medicine or diagnosis of a client's condition. Atlanta Medical Institute reserves the right to restrict service to, or decline acceptance of the client.

This is to certify that I am requesting services on my own initiative and I realize that the biofeedback practitioner does not diagnose ailments or prescribe treatments. I release Atlanta Medical Institute, it's directors, employees, and sub-contractors from any liability for claims resulting from the use if this device.

Signature_____ Date_____

Waiver of Claims and Informed Consent Agreement

Please sign and date below

Atlanta Medical Institute, LLC (hereafter "AMI") and the individual who purchases a medical treatment from AMI (hereafter the "Patient") enter into this Patient Waiver of Claims and Informed Consent Agreement (hereafter "Agreement") in consideration of the promises contained herein and other agreed adequate consideration. The Parties understand, accept and agree to all the terms, conditions and provisions of this Agreement on the date written below. I, the undersigned Patient, accept, understand, and agree to the following terms, provisions and conditions:

Independent Contractors of AMI

Independent contractors and medical organizations that may provide medical services, physician services, laboratory services, pharmacy services, Biofeedback, other services, prescription drugs and products to Patient on behalf of AMI include, but are not limited to the following: a) physicians and medical organizations that conduct Patient's physical examination, evaluate Patient's physical exam results, medical history, medical complaint, and prescribe medication or medical treatment to Patient; b) diagnostic medical testing laboratories; and c) pharmacies that dispense prescribed medication directly to Patient.

Medical Service and Products Provided: Physical Examination, Prescribing or Treatment, Dispensing Pharmacy and Supervision of Patient Medical Treatment

The physician conducting the physical examination of Patient, or other physician within the medical organization employing the examining physician if the examining physician is not available (hereafter the "Physician"), shall be responsible for supervising medical treatments prescribed to Patient. Patient agrees to undergo a medical laboratory urine or blood test if required for the AMI treatment program purchased. Physician shall evaluate the physical exam report, medical history report, any laboratory test report and the medical complaint of Patient in determining whether or not to issue a prescription for a medical treatment requested by Patient.

Physician Conducts a Physical Examination and Evaluates Patient's Medical History and Medical Complaint Before Prescribing any Medical Treatment

Patient understands that AMI does not anticipate any adverse effect to arise as a result of any medical program provided to Patient. Patient also understands that the practice of medicine is not an exact science and that no specific outcome from treatment can be assured to Patient. **Patient is freely seeking medical services offered by AMI with an understanding that the Physician will conduct the physical examination of Patient and supervise Patient's medical treatment**. Patient is also aware that all medical programs offered by AMI require that the Physician prescribe any medical program offered by AMI. Patient has
examined and requested a medical program offered by AMI and understands the nature and risks inherent in the medical program purchased from AMI. Patient represents that all information provided to Physician and AMI by Patient is complete, correct and accurately reflects Patient's known medical condition.

Patient Agrees to Provide Accurate and Complete Information to Physician and AMI

Physician shall obtain Patient information, draw conclusions and make decisions based upon Patient's honest responses to questions presented to Patient. Patient represents that all responses to questions regarding Patient's medical condition shall be truthful, accurate and complete. Patient understands that failure to provide truthful, accurate and complete information to Physician or AMI on any data collection form could cause Physician to unknowingly make an inappropriate treatment decision affecting the physical or mental health of Patient.

Physician is an Independent Contractor of AMI. Patient understands that AMI does not practice medicine and functions as a medical administration organization coordinating the services and products of medical organizations

Unless otherwise communicated by AMI to Patient in writing, the Physician is an independent contractor of AMI and is not an agent or employee of AMI. AMI does not direct, control or influence the treatment decisions made by Physician with respect to Patient care or any Patient request for specified treatment. AMI compensates Physician the same amount for professional services rendered regardless of whether or not a prescription is issued for treatment sought by Patient. Patient understands and agrees that Patient medical records become the property of AMI; and that, in addition, AMI will have continuing access to and the right to copy and retain any and all portions of Patient medical records. Patient understands and agrees that a duplicate copy of Patient medical records become the property of the medical organization or physician that conducts Patient's physical examination; and that, in addition, said medical organization and examining physician shall have continuing access to and the right to copy and retain any and all portions of Patient's medical records.

Miscellaneous Provisions

(a) Patient understands that prescription medications cannot be returned to the dispensing pharmacy, AMI or any other individual or entity after the medication has been dispensed to Patient. (b) This Agreement represents the complete and entire agreement between the parties to it. No prior written or electronic agreement, verbal communication or verbal agreement may be offered or used to alter any terms or condition of this Agreement; nor shall such extrinsic agreements be effective or binding between the parties regarding any term or condition of this Agreement or be offered or introduced to show intent of a party to any matter pertaining to this Agreement. (c) Patient agrees that a delivery receipt for a shipment from AMI, its contractors, any independent pharmacy, or any delivery service signed by a person at the Patient's shipping address shall constitute conclusive evidence of the delivery and receipt of the prescription drug and full performance of the obligations of AMI to Patient. Patient irrevocably agrees and instructs Visa, MasterCard, or other credit card provider or processor, and Patient's bank to withdraw any asserted credit card dispute submitted should independent evidence of delivery of the shipment to Patient's address be provided by AMI. Federal Express or other delivery services reported delivery to the Patient's shipping address on the Federal Express or delivery service's website shall constitute delivery to Patient. Federal Express's or other delivery service's reported delivery to the Patient's shipping address on the Federal Express or other delivery service's website with a reported wavier of signature on file with Federal Express or other delivery service for deliveries to Patient's shipping address shall also constitute delivery of the prescription drug and its receipt by Patient. The reported delivery of the prescription medicine shipment by the United States Postal Service to the Patient's address on its website shall also constitute delivery to Patient and conclusive evidence of the full performance of this Agreement by AMI. AMI shall use its best efforts in good faith to assure a high level of service to Patient, including the timely delivery of all prescription medicine dispensed by the responsible pharmacy.

Patient's Representations and Assurances

(a) Patient is over 18 years of age. (b) Patient agrees that any claim or action brought by Patient against AMI, its agents, officers, directors, owners, shareholders, contractors and affiliated companies shall be brought in Fulton County, Georgia, which is granted exclusive jurisdiction and venue of claims brought by Patient, or any assignee, against said parties, arising from any transaction or occurrence involving Patient and said parties. Patient unconditionally and expressly waives all claims and defenses that might be brought or asserted by Patient in any such action against said parties. Patient agrees that this agreement is voluntary, and that it is binding to any individual or entity claiming by or through Patient or on behalf of Patient. Patient further agrees to pay all attorneys fees and costs incurred by AMI as they are incurred in the event Patient brings any action or claim against AMI in violation of this provision; or in violation of any term, condition or provision of this Agreement; or brings an action against AMI, or any of its officers, directors, employees, agents or contractors inconsistent with Patient's waiver of all claims and defenses as set forth in this Agreement. (c) Patient is aware of potential side effects associated with medication requested by

Patient and personally accepts all risks involved in taking such medication; and Patient agrees not to seek any indemnification, damages of any kind, or any other liability from AMI, its officers, directors, employees, parent, subsidiaries, affiliates, contractors, agents, or any medical organization or pharmacy that provides Patient with medical services or products at the request of AMI in the event Patient experiences any of the adverse side effects of prescribed medication. (d) Patient understands that AMI, its employees, agents, contractors, contracting physicians, nurses, sales personnel, administrative personnel and other entities and organizations and their employees who provide medical services or products to Patient at the request of AMI cannot guarantee that the prescription medication or treatment sought by Patient will provide the results sought by Patient. (e) Patient has obtained and consulted with Patient's primary care physician and/or pharmacist and Patient is not taking any medication or combination of medications that will make the medication requested from AMI inadvisable to take (contraindicated); and Patient agrees to advise Patient's primary care physician of any medications obtained through AMI before commencing use of such medication. (f) Patient agrees that this Agreement shall serve as Patient's authorization for AMI to release or disclose Patient's medical information to medical organizations rendering medical services to Patient at the request of AMI. This consent does not give AMI the right to sell Patient's name or information to any third party.

PATIENT UNCONDITIONALLY AND EXPRESSLY WAIVES ANY AND ALL CLAIMS AND DEFENSES AGAINST AMI, ITS SHAREHOLDERS, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS, CONTRACTING PHYSICIANS, AND ANY AND ALL ORGANIZATIONS AND THEIR EMPLOYEES PROVIDING SERVICES OR PRODUCTS TO PATIENT ON BEHALF OF OHL FOR ANY CLAIM RELATING DIRECTLY OR INDIRECTLY TO ANY SERVICE OR PRODUCT PURCHASED BY PATIENT FROM OHL. THIS WAIVER INCLUDES, BUT IS NOT LIMITED TO, ANY ILLNESS, BODILY INJURY OR OTHER ADVERSE PHYSICAL, MENTAL OR MEDICAL CONDITION SUSTAINED BY PATIENT AS A RESULT OF A SERVICE OR PRODUCT PURCHASED FROM AMI BY PATIENT OR PROVIDED TO PATIENT BY ANY MEDICAL ORGANIZATION OR CONTRACTING PHYSICIAN OF AMI. PATIENT EXPRESSLY WAIVES ANY AND ALL DEFENSES IN ANY ACTION BROUGHT BY PATIENT AGAINST AMI OR ANY OF ITS CONTRACTORS. PATIENT UNDERSTANDS THE NATURE OF THIS WAIVER OF CLAIMS AND DEFENSES AND VOLUNTARILY AGREES TO THIS WAIVER OF CLAIMS AND DEFENSES. THIS WAIVER OF CLAIMS AND DEFENSES IS BINDING TO ANY INDIVIDUAL OR ENTITY CLAIMING BY, OR THROUGH, OR ON BEHALF OF PATIENT. PATIENT HOLDS OHL, ITS AGENTS, SHAREHOLDERS, DIRECTORS, OFFICERS, EMPLOYEES AND CONTRACTORS HARMLESS AND INDEMNIFIES EACH FOR ANY LIABILITY ARISING IN CONNECTION WITH THE TREATMENT PROGRAM PURCHASED FROM AMI BY PATIENT.

If any provision in this agreement is found to be unenforceable, such finding does not invalidate the entire agreement, but only that particular provision.

Signature: _____ Date: _____

Atlanta Medical Institute
3365 Piedmont Road
Tower Walk Suite 1250
Atlanta, Georgia 30305

PRIVACY NOTICE
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.

INTRODUCTION
The Atlanta Medical Institute, Inc. understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Facility's Privacy Officer or you can access it on our website at www.atlantamedicalinstitute.com.

PERMITTED USES AND DISCLOSURES
We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

• *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.

• *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

• *Health care operations* means the support functions of our facility related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the deidentified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

• We may contact you to provide appointment reminders for treatment or medical care.

• We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

• We may disclose to your family or friends or any other individual identified by you protected health information directly relevant to such person's involvement with your care or payment for your care. We may use or disclose your protected health information to notify, or assist in the notification of a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

• When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

• We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

• We may contact you as part of our efforts to market our Facility's services as permitted by applicable law.

• Subject to applicable law, we may make incidental uses and disclosures of protected health information. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

• **[We may use or disclose your protected health information for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.]**

• We will use or disclose protected health information about you when required to do so by applicable law.

• **[Note: In accordance with applicable law, we may disclose your protected health information to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Facility as required by applicable law.]**

SPECIAL SITUATIONS
Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

• 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 organ or tissue donation and transplantation.
• Military and Veterans . If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

• Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.

• Public Health Activities . We may disclose health information about you for public health activities, including disclosures:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

• Health Oversight Activities . We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.

• 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. We may also disclose health discovery request, or other lawful process by someone else involved in the dispute, but only if the Facility is given assurances that efforts have been made by the person making the request to tell you about the request or to obtain an order protecting the information requested.

• 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 process;

- To identify or locate a suspect, fugitive, material witness, or missing person;

- About the victim of a crime under certain limited circumstances;

- About a death we believe may be the result of criminal conduct;

- About criminal conduct on our premises; and

- In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person
who committed the crime.

• Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. Such disclosures may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

• National Security and Intelligence Activities. We may release health information about you to authorized Federal officials for intelligence,

counterintelligence, or other national security activities authorized by law.

• Protective Services for the President and Others. We may disclose health information about you to authorized Federal officials so they may provide protection to the President or other authorized persons or foreign heads of state or may conduct
special investigations.

• Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

• Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual. **Note**: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health
information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION
Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS
1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Facility's Privacy Officer.

2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Facility's Privacy Officer.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Facility records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;
(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
(iii) for protected health information involving laboratory tests when your access is restricted by law;
(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;
(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information. In order to inspect and copy your health information, you must submit your request in writing to the Facility's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request. We may also deny a request for access to
protected health information if:
• a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
• the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
• the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person. If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
(ii) is not part of your medical or billing records or other records used to make decisions about you;
(iii) is not available for inspection as set forth above; or
(iv) is accurate and complete. In any event, any agreed upon amendment will be included as an addition to, and not a replacement of,
already existing records. In order to request an amendment to your health information, you must submit your request in writing to the Facility's Privacy Officer, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;
(ii) incident to a use or disclosure otherwise permitted or required by applicable law;
(iii) pursuant to a written authorization obtained from you;
(iv) to persons involved in your care or for other notification purposes as provided by law;
(v) for national security or intelligence purposes as provided by law;
(vi) to correctional institutions or law enforcement officials as provided by law;
(vii) as part of a limited data set as provided by law; or
(viii) that occurred prior to April 14, 2003.

To request an accounting of disclosures of your health information, you must submit your request in writing to the Facility's Privacy Officer. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

COMPLAINTS
If you believe that your privacy rights have been violated, you should immediately contact the Facility's Privacy Officer. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON
If you have any questions or would like further information about this notice, please contact the Facility's Privacy Officer, Aaron Rosenhaft, Director of Operations, 404-264-9553. This notice is effective as of April 14, 2003.

I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY NOTICE:

_____ _____
Signature ***Date***

Refused:_____ _____
Signature ***Date***

Atlanta Medical Institute
3365 Piedmont Road Tower Walk Suite 1250
ATLANTA, GEORGIA 30305
404-264-9553 (Phone) 404-266-2294 (Fax)