HIPAA NOTICE OF PRIVACY PRACTICES

and

CONSENT and SCOPE OF PRACTICE NOTICES

Judd Natural Health and Kerry J Dyer LAC PLLC

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case or computer and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders -· Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, email, text, or with the person who answers the call.· You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Sign-in Log This Practice may maintain a sign-in log for individuals seeking care and treatment in the office. This sign-in sheets are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or

another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION - Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization - You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions - You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to - Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. If your provider is using Acusimple EHR documents are available to view in your portal. If you cannot access the Acusimple portal please contact the clinic in writing for assistance.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card. Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer. Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement. Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS:

1. The Practice: • Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. • Is required to abide by the terms of this Privacy Notice.• Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains. • Will distribute any revised Privacy Notice to you prior to implementation. • Will not retaliate against you for filing a complaint.

Scope of Practice

- *Kerry Dyer LAc, LMT, Dipl O.M.* - 2005 MAcOM Oregon College of Oriental Medicine - 1999 BA University of Alaska 1997 East West College of the Healing Arts - Certified NADA Practitioner - Certified Qigong Instructor/Teacher of Liu Dong Qi Gong Method - WA AC00002782 WA MA00011217 NCCAOM Dipl. O.M. 27533 - Yoga Teacher/Instructor 200 RYT My Vinyasa Practice

1. Eastern medicine means a health care service using Eastern medicine diagnosis and treatment to promote health and treat organic or functional disorders.

2. The scope of practice for an acupuncturist or acupuncture and Eastern medicine practitioner in the state of Washington includes the following:(a) Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;(b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;(c) Moxibustion;(d) Acupressure;(e) Cupping;(f) Dermal friction technique;(g) Infra-red;(h) Sonopuncture;(i) Laserpuncture;(j) Point injection therapy is defined as meaning the subcutaneous, intramuscular and intradermal injection of substances limited to saline, sterile water, herbs, minerals, vitamins in liquid form, and homeopathic and nutritional substances, consistent with the practice of acupuncture or Eastern medicine to stimulate acupuncture points, ashi points, trigger points and meridians. Pont injection therapy does not include injection of controlled substances contained in Schedules I through V of the uniform controlled substances act, chapter 69.50 RCW or steroids as defined in RCW 69.41.300; (k) Dietary advice and health education based on Eastern medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;(l) Breathing, relaxation, and Eastern exercise techniques;(m) Qi gong;(n) Eastern massage and Tui na, which is a method of Eastern bodywork,characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and(o) Superficial heat and cold therapies.

3. Side effects may include, but are not limited to:(a) Pain following treatment;(b) Minor bruising;(c) Infection;(d) Needle sickness; and(e) Broken needle.

4. The patient must inform the acupuncturist or acupuncture and Eastern medicine practitioner if the patient is pregnant or has a severe bleeding disorder or electrical implanted devices such as a pacemaker prior to any treatment. Patients must inform their provider if they have a serious medical condition and may be required to sign a waiver or request records from their primary care provider to continue care.

Consent to Treat - I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories

to this form or not. I understand telehealth services can be utilized only if I am physically in WA state. If I have a potentially serious disorder I acknowledge that failure to pursue treatment from my primary health care provider (or other providers such as a nurse practitioner, medical doctor, etc) may involve risks such as worsening of my condition.

I understand that methods of treatment may include, but are not limited to, acupuncture, qigong, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, physical medicine services, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

"Massage" and "massage therapy" mean a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes. Massage therapy includes techniques such as tapping, compressions, friction, reflexology, Swedish gymnastics or movements, gliding, kneading, shaking, and fascial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage therapy does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of thrusting force, nor does it include genital manipulation. See WAC 246-830-550 for additional limitations on massage practice.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the clinical and

administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

Yoga, Qigong, Movement, Relaxation Techniques Waiver of Liability

If I participate in yoga, qigong, movement, or other relaxation techniques in an individual or group setting, inside or outside the clinic, I release instructors and clinic from any responsibility and/or liability concerning the application, processing, and/or consequences of qigong, yoga, movement, and relaxation techniques that are or include being seated, standing, moving, balancing, stretching, laying down, in an individual or group setting that I elected to and chose to participate in. I consent to have the above described yoga, qigong, movement, and/or relaxation services of my choice applied. I understand the risks of sore muscles, injury to joints and/or muscles, balance concerns, and other unforeseen events. I release Kerry J. Dyer L.Ac. PLLC and Judd Natural Health, its employees and its agents harmless against any and all liability, damage, and/or expenses arising out of or in connection with actions, claims, and/or damages resulting in personal injuries and disabilities (physical and/or psychological) as a result of the services provided today and I agree to voluntarily participate understanding these risks and their outcomes.

COVID-19 Safety

We recommend masking inside the clinic. Other general health and safety measures include: staff and providers of Judd Natural Health will mask; surfaces are routinely disinfected; hepa filters used when available; ventilation increased if possible. I will self-screen for illness, including COVID-19 prior to each visit. I understand there is no fee associated with canceling appointments due to COVID exposure concerns or symptoms. I understand patients and staff follow COVID precautions including masking and rescheduling appointments if patient or staff has a positive COVID test or COVID symptoms within the last 7 to 10 days. I understand I can ask my provider any questions regarding treatment and clinic guidelines may change. I understand my provider may work with me to find an appropriate time and day for appointments if I am concerned about exposure to COVID or other infections.

I understand there may be times my provider requires masking to receive TX for various reasons including but not limited to: my current symptoms, increased infectious disease activity locally, etc. Masks can be provided at no cost. I understand I may have an elevated risk of contracting COVID-19 by being in a healthcare office. I am informed that my provider and clinic have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you to proceed with providing care. I understand Judd Natural Health shares this office space with other businesses which may have different safety protocols in place.