





## 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.

ProBalance, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

*“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with ProBalance, Inc.”*

*“It is our policy to provide a substitute health care provider, authorized by ProBalance, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”*

#### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

*“As a courtesy to our patients, we may submit an itemized billing statement to your insurance carrier for the purpose of payment to ProBalance, Inc. for health care services rendered. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”*

#### **Workers’ Compensation**

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

#### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

#### **Judicial and Administrative Proceedings.**

We may disclose your health information in the course of any administrative or judicial proceeding.

#### **Law Enforcement.**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

#### **Deceased Persons.**

We may disclose your health information to coroners or medical examiners.

#### **Organ Donation.**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

#### **Research.**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

#### **Public Safety.**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

#### **Specialized Government Agencies.**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

#### **Change of Ownership.**

In the event that ProBalance, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that ProBalance, Inc. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that ProBalance, Inc. amend your protected health information. Please be advised, however, that ProBalance, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by ProBalance, Inc..
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

ProBalance, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, ProBalance, Inc. is required by law to comply with this Notice.

ProBalance, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Ada Wells by calling this office at (510) 523-1900. If Ada Wells is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your Privacy rights, or how ProBalance, Inc. has handled your health information should be directed to Ada Wells by calling this office at (510) 523-1900. If Ada Wells is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of July 1<sup>st</sup>, 2008.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide ProBalance, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

## Release of Liability for Fitness/Wellness Activities

There may come a time when clients new to ProBalance or existing ProBalance patients/clients transition from one-on-one physical therapy care to the initiation of selected individual, group, and/or independent fitness/wellness activities located in the ProBalance facility that may or may not be supervised by a physical therapist. In consideration of being allowed to participate in any way in these programs, the undersigned acknowledges, appreciates and agrees that:

1. While physical therapists at ProBalance may be onsite during the fitness/wellness client's visit, activities and interventions performed and supervised by non-physical therapists are not considered physical therapy, and therefore are undertaken by the client at his/her sole risk.
2. A physical therapist may offer advice to the fitness/wellness client or client's instructor/practitioner at the client's request based on prior clinical findings or a brief screening/consultation. However, a brief consultation with a ProBalance Physical Therapist is not a substitution for a full physical therapy evaluation or direct care visit by the physical therapist. Further activities and interventions with the non-physical therapist are NOT to be considered supervision by a physical therapist and are therefore undertaken by the client at his/her sole risk.
3. Group classes (sessions designed for more than one person), including those instructed by a physical therapist, fall into the category of a "Fitness/Wellness Activity" and are undertaken by the patient/client at his/her sole risk.
4. The use of all ProBalance facilities – exercise equipment including Pilates apparatus, props, weights, treadmills, and stationary cycles– is undertaken by the patient/client at his/her sole risk.
5. The risk of injury from activities involved in this program is significant, including the potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist; and,
6. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releasees or others, and assume full responsibility for my participation; and,
7. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
8. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless ProBalance, Inc., their officers, officials, agents, independent contractors, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("Releasees"), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the releasees or otherwise, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

\_\_\_\_\_  
PARTICIPANT'S SIGNATURE

\_\_\_\_\_  
DATE

*FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITYAGE  
(UNDER AGE 18 AT TIME OF REGISTRATION)*

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release, as provided above, of all the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law.

\_\_\_\_\_  
PARENT/GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE

EMERGENCY PHONE: \_\_\_\_\_