



HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
SUMMARY OF PATIENT/CLIENT INFORMATION PRACTICES

This summary is provided to assist you in understanding the Notice of Privacy Practices and describe how medical information about you may be used or discussed and how you can get access to this information.

The Notice of Privacy Practices contains a detailed description of how ProAct Medical, LLC Strategies will protect your health information, your rights as a patient/client, and our common practices in handling patients'/clients' health information. Please refer to that Notice for further information.

Uses and Disclosure of Health Information

ProAct Medical, LLC will use your personal health information primarily for communicating test results with health care providers. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process claims for services rendered by ProAct Concussion Management Strategies. Lastly, we may disclose your health information to conduct internal administrative activities such as quality assessment, licensing purposes, and/or for training students.

ProAct Medical, LLC may also use or disclose your personal health information without your written authorization for emergencies, limited research purposes, auditing purposes, public health/statistical purposes, and when required by court order search warrants, subpoenas, and otherwise required by law. In any other situation, or policy is to obtain a signed authorization before we will disclose your personal health information. If you provide us with a written authorization to release your information, you may revoke that authorization to stop future disclosures at any time.

Patient's Individual Rights

As a client of ProAct Medical, LLC you have the following rights:

- To receive or obtain a copy of your personal health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we correct any inaccurate or incomplete information
- To receive notice of our Privacy Practice

Concerns and Complaints

If you have a question, concern, or complaint regarding our Privacy Practices, please refer to the Notice of Privacy Practices

I have read and fully understand ProAct Medical, LLC Notice of Patient Privacy Information Practices. I therefore freely affix my signature below with full understanding of all of the above.

Client Signature

Date

Print Client Name

Signature of Client Representative/Parent
(if applicable)

Date