THE METROPOLITAN NEUROSURGERY GROUP LLC

NOTICE OF PRIVACY PRACTICES

Please Retain for Your Records

This notice describes how medical information about you may be used or disclosed and how you can access this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. This notice will be effective from September 1, 2006.

OUR RESPONSIBILITY

We are required by law to maintain the privacy of your protected health information and to provide you with notice of your legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

We are permitted to use and disclose your health care records for purposes of treatment, payment and health care operations without specific written authorization.

Treatment:	We may use medical information about you for providing, coordinating, or managing health care and related services by one or more health care providers. We will also provide your other practitioners with copies of various reports that should assist them in treating you.
Payment:	We may use and disclose medical information about you to obtain reimbursement for services, confirming coverage, billing or collecting activities and utilization review.
Regular health care operations:	We may use medical information in the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.
Business associates:	If there are services provided through contracts with business associates such as laboratory test, radiology, etc., we may disclose some of your health information so that they can perform the job. To protect your health information, we require the business associates to safeguard your information.
Notification and communication with family:	We may use or disclose information to notify friends and family members that are directly involved in your care or who assist in taking care of you. If you are present, we will request your permission if possible, before we share or give you the opportunity to refuse permission. In case of emergency, we will share only the health information that is directly necessary for your health care according to our professional judgment.

Research:	We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols has approved their research.
Disaster Relief:	We may share medical information with public or private organization that can legally assist in disaster relief efforts.
Fundraising and Marketing:	We will not contact you as part of fundraising or marketing
Funeral Directors, Coroner, Medical Examiner**:**	We may disclose health information to identify a deceased individual or to identify the cause of death to funeral directors to perform their jobs.
Organ procurement organization:	Consistent with the law, we may disclose health information to organ procurement organizations, transplantation, including organ donation banks as necessary to facilitate organ or tissue donation and transplantation.
Public Health:	As required by law, we may disclose your health information to public health or legal authorities to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
Law Enforcements, Court Orders and Judicial and Administrative Proceedings:	Law enforcements, Court Orders and Judicial and Administrative Proceedings: We may disclose information in response to court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. We may share limited information with a law enforcement official concerning medical information of a suspect, fugitive, material witness, crime victim or missing person. If you are an inmate of a correctional institution, we may disclose to the institution or agents necessary information for your health and the health and safety of others.
Specialized Government Functions:	We may disclose health information for military personnel and veterans for national security and intelligence activities if required by appropriate authorities. We may disclose to federal officials for intelligence and national security activities authorized by law.
Food and Drug Administration (FDA):	As required by law, we may disclose to FDA health information relative to adverse events with respect to food, supplements and post marketing surveillance to enable product recalls, repairs or replacement.
Victims of Abuse, Neglect, or Domestic Violence:	We may disclose to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or crime.
Appointment Reminders:	We may use and disclose medical information to remind you of an appointment.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing. The Metropolitan Neurosurgery Group LLC is required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.	

YOUR INDIVIDUAL RIGHTS

You have certain rights in regards to you protected health information, which you can exercise by presenting a written request to the practice address below. You may request restriction on certain uses and disclosures of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in case of an emergency. You may request to receive confidential communication of protected health information from us by alternative means or locations and to request an amendment to your protected health information. You may request to receive an accounting of disclosures of your protected health information outside of treatment, payment and health care operations. You may obtain a paper copy of notice of information practices upon request, access, inspect and copy your health record.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

The Metropolitan Neurosurgery Group, LLC
8401 Connecticut Avenue, Suite 220
Chevy Chase, MD 20815-5829
Phone 301.654.9390 Fax 301.654.9394

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
Telephone: 877-696-6775

THE METROPOLITAN NEUROSURGERY GROUP LLC

Please sign and return to

The Metropolitan Neurosurgery Group LLC / 8401 Connecticut Avenue, Suite 220 / Chevy Chase MD 20815

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Fraser Henderson and Metropolitan Neurosurgery Group (collectively labeled "*Physician"*) agree to maintain Privacy of _____ ("*Patient/Responsible party*") as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment - the sole exceptions being communication to a confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If Patient does prepare commentary for publication about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Physician. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Physician; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Physician's practice.

Physician feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Physician's last date of service to Patient; or (b) three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS ___DAY OF _____, 201__

Patient/Responsible Party: _____

Please sign and return to

The Metropolitan Neurosurgery Group LLC / 8401 Connecticut Avenue, Suite 220 / Chevy Chase MD 20815

THE METROPOLITAN NEUROSURGERY GROUP LLC

HIPAA PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

ACKNOWLEDGEMENT OF NOTIFICATION

The “Mutual Agreement to Maintain Privacy” contains Metropolitan Neurosurgery Group’s "Notice of Privacy Practices."

The Agreement, which is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides information about how The Metropolitan Neurosurgery Group LLC may use and disclose protected health information about you.

Our Mutual Agreement states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Mutual Agreement to Maintain Privacy.

Patient Signature Date

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare benefits be made on my behalf to The Metropolitan Neurosurgery Group LLC for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and it's agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan (s) as required by my insurance carrier (s). All co-insurance must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient Signature Date

Print Patient Name

Please sign and return to

The Metropolitan Neurosurgery Group LLC / 8401 Connecticut Avenue, Suite 220 / Chevy Chase MD 20815