CINCINNATI™
ACUPUNCTURE CLINIC

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NOTICE OF PRIVACY PRACTICES

Effective Date: April 23, 2026 | 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.

OUR COMMITMENT TO YOUR PRIVACY

Cincinnati Acupuncture Clinic, led by **Inesa Zelepuhin, L.Ac., Dipl. Ac.**, a licensed acupuncturist nationally certified through NCCAOM and licensed by the State of Ohio Medical Board, is deeply committed to protecting the privacy of your health information. We are required by law (45 CFR Parts 160 and 164, the HIPAA Privacy Rule) to maintain the privacy of your Protected Health Information (PHI), to provide you with this Notice of our legal duties and privacy practices, and to follow the terms of the Notice currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways we may use and disclose your health information without your specific written authorization:

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your acupuncture care and any related services. For example, your acupuncturist may share information with a referring physician or other health care provider involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services provided. This may include submitting claims to insurance companies, billing offices, or other third-party payers.

Health Care Operations: We may use and disclose your PHI for our clinic operations, including quality assessment, training, audits, and other business activities necessary to run the practice.

Required by Law: We will disclose your PHI when required to do so by federal, state, or local law.

Public Health Activities: We may disclose your PHI to public health authorities for activities such as disease reporting, injury prevention, or reporting adverse effects of medications.

Health Oversight: We may disclose your PHI to a health oversight agency for audits, investigations, inspections, or licensing activities authorized by law.

Research: Under certain circumstances, we may use or disclose PHI for research purposes after an institutional review board or privacy board approves the research protocol.

Serious Threat to Health or Safety: We may use or disclose PHI to prevent a serious threat to the health or safety of you, another person, or the public.

Military and Veterans: If you are a member of the armed forces, we may disclose your PHI as required by military command authorities.

Workers' Compensation: We may disclose your PHI for workers' compensation or similar programs providing benefits for work-related injuries.

Appointment Reminders: We may use your PHI to contact you with appointment reminders or information about treatment alternatives.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI not described above will be made only with your written authorization, including:

- Marketing purposes
- Sale of your PHI
- Most uses of psychotherapy notes
- Any other purpose not described in this Notice

You may revoke your authorization in writing at any time, except to the extent that we have already taken action in reliance on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy

You have the right to inspect and obtain a copy of your PHI in a designated record set, such as your medical record and billing records. We may charge a reasonable, cost-based fee for copies. Please submit your request in writing to our Privacy Officer.

Right to Amend

If you believe PHI we have about you is incorrect or incomplete, you may request an amendment. We may deny your request in certain circumstances, but we will explain any denial in writing.

Right to an Accounting of Disclosures

You have the right to request a list of disclosures we have made of your PHI for purposes other than treatment, payment, and health care operations. The request must be in writing and specify the time period (no more than six years prior to the date of the request).

Right to Request Restrictions

You have the right to request that we restrict how we use or disclose your PHI for treatment, payment, or health care operations. We are not required to agree to your request, except when you pay out-of-pocket in full for a service and request that we not disclose information to your health plan about that service.

Right to Confidential Communications

You have the right to request that we communicate with you about health matters in a certain way or at a certain location (e.g., only at home or only by mail). We will accommodate reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice at any time, even if you have agreed to receive it electronically. Contact our office to request one.

Right to Notification of a Breach

You have the right to be notified if there is a breach of your unsecured PHI that may compromise the privacy or security of your information.

OUR DUTIES

- We are required by law to maintain the privacy of your PHI.

- We are required to provide you with this Notice of our legal duties and privacy practices.
- We are required to follow the terms of the Notice currently in effect.
- We reserve the right to change our privacy practices and apply the revised practices to your PHI already on file. If we make a material change, we will provide a revised Notice at your next visit or upon request.
- We will not retaliate against you for filing a complaint about our privacy practices.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

By signing below, I acknowledge that I have received a copy of Cincinnati Acupuncture Clinic's **Notice of Privacy Practices**. I understand that this clinic may use and disclose my protected health information to carry out treatment, payment, and health care operations, and for other purposes permitted or required by law. I understand that I have the right to request a copy of this Notice at any time.

Patient Name (Print) _____ Date of Birth _____ Date _____

Patient Signature (or Guardian if minor) _____ Relationship to Patient (if applicable) _____

Staff Representative _____ Date Provided to Patient _____

For Office Use Only: ☐ Notice provided and signed ☐ Notice provided; patient declined to sign ☐ Emergency — notice provided at next visit