NOTICE OF: HIPAA COMPLIANCE
SIGNATURE ON FILE

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly or indirectly. 2) Obtain payment from third party payers. 3) Conduct normal healthcare operations such as quality assessments and physical certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

By signing below:

-You are acknowledging that Lumina abides by HIPAA privacy policy standards, set forth by the The Health Insurance Portability and Accountability Act of 1996.

-You are allowing Lumina to bill any insurance that you may have.

_____ _____

Signature Date