

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures we described below **we will not sell or provide any of your health information to any outside marketing organization.**

We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if /when you come in for treatment.

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Any correspondence should be addressed to:

Attn: **HIPAA** Compliance Officer, Moriah Salzman
904 N. McQueen Rd Suite 104
Gilbert, AZ 85233

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

1. Your Chiropractor or staff may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. Our insurance billing staff may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. Your Chiropractor or staff may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.
4. Your Chiropractor or staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. test results). 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine and/ or mailed.

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives and etc.)

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the order of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers with communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the five preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(1)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding how/ where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

INSPECTING/ COPYING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our office and/ or have a copy made for you. The health information is available up to seven years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/ or have them copied. There will be a charge of \$.50 per page copied. Copies can be made of your x-rays for a charge of \$10.00 for each film. The original film is the property of this office because we are required by law to keep it in our records. Original films can only be released on referral to another physician.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- those disclosures required for your treatment, to obtain payment for services, to run our practice,
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12 month period without any charge. For any additional requests, a fee will be charged. At the time of your request you will be notified of the cost and you will have the opportunity to withdraw or modify you request.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Written comments should be addressed to our office address at A Plus Chiropractic Care 904 N. McQueen Rd Suite 104 Gilbert, AZ 85233 or Secretary for Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Bldg, Washington, D.C. 20201. We respect your right to file a complaint and will not take any action against you. This notice is effective as of April 14, 2003.

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By Signing below, I acknowledge that I have received a copy of this notice.

Patient Name Printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative printed

Personal Representative Signature

Description of personal Representative's authority to act for the patient