

# Chiropractic Whole Health

## PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Practice is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your health condition(s), past, present and future, and the care and treatment you receive from the Practice, and can be used to identify you specifically. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

Our office is required by state and federal law to provide you with this notice. Our office is also legally required to maintain the privacy of protected health information and to follow the privacy practices that are described in this notice. We reserve the right to change the terms of this Notice and our privacy policies at any time. When we make an important change to our privacy policies, we will promptly change this notice and post a new notice in the office. You may also obtain any new notice by asking for one at any time. This notice goes into effect April 14, 2003.

### **CONSENT REQUIRED:**

1. The Practice may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Practice to use and/or disclose your PHI for the purposes of:
  - (a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice’s staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.
  - (b) Payment – In order to get paid for services provided to you, the Practice will provide your provider your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
  - (c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice’s personnel in providing care to you.

In the event you authorize us to use or disclose your PHI in ways other than those described above, you have the right to revoke that authorization at any time by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

### **NO CONSENT REQUIRED**

1. The Practice may use and/or disclose your PHI, without Consent from you, in the following instances:
  - (a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

- (b) Business Associate—To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard you PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
- (c) Personal Representative—To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- (d) Emergency Situations—
  1. For the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
  2. to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
- (e) Communication Barriers—If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
- (f) Public Health Activities—Such activities include, for example, information collected by a public health authority, as authorized by law to prevent or control disease.
- (g) Abuse, Neglect, or Domestic Violence— To a government authority if the Practice is required by law to make such disclosures. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
- (h) Health Oversight Activities—Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community’s health care system.
- (i) Law Enforcement, Judicial and Administrative Proceeding—For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued Subpoena.
- (j) Law Enforcement Purposes—In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
- (k) Coroner or Medical Examiner, Funeral Director- The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
- (l) Organ, Eye or Tissue Donation- If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
- (m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.
- (n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes, that such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.
- (o) Specialized Government Functions – This refers to disclosures of PHI that relate primarily to military and veteran activity.
- (p) Workers’ Compensation – If you are involved in a Workers’ Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers’ Compensation system.
- (q) National Security and Intelligence Activities – The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.
- (r) Military and Veteran – If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

## **APPOINTMENT REMINDER**

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

## **FAMILY/ FRIENDS**

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

## **AUTHORIZATION**

Uses and/or disclosures, other than those described above will be made only with your written Authorization.

## **YOUR RIGHTS**

You have the right to:

- (a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
- (b) Request restrictions on certain use and /or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- (c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- (d) Inspect and copy your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
- (e) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice

- may charge you for the cost of providing additional list. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
- (f) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
  - (g) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
  - (h) To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Dr. Robert Smith, at 610-438-2015 or email at [DrRob@DrRobertSmith.com](mailto:DrRob@DrRobertSmith.com).

### **PRACTICE'S REQUIREMENTS**

The Practice:

1. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practice with respect to your PHI.
2. Is required by State law to maintain a higher level of confidentiality with respect to certain portions of you medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes: none
3. Is required to abide by the terms of this Privacy Notice.
4. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
5. Will distribute any revised Privacy Notice to you prior to implementation.
6. Will not retaliate against you for filing a complaint.

### **EFFECTIVE DATE**

This Notice is in effect as of April 14, 2003.

# CHIROPRACTIC WHOLE HEALTH

## PATIENT CONSENT FOR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I \_\_\_\_\_, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and / or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice has explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my rights to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice may not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative  
(E.g., Attorney-In-Fact, Guardian, Parent if minor):

\_\_\_\_\_  
Relationship

Date Signed \_\_\_ / \_\_\_ / \_\_\_

Witness: \_\_\_\_\_

