

HIPPA HAPPENINGS

*This notice describes how your health information may be used and how you can gain access to this information.
Please review it carefully.*

Our Promise To You our Valued Patient....

This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal (HIPPA-Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to someone outside our office.

Why a Privacy Policy Now?

The most significant variable that has motive the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also within the Internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only when required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand procedures and your rights as a valued patient.

How Your Health Information May Be Used to Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personal, clinical pathology laboratories or other health professionals providing you treatment.

Your health information may be included with an invoice for the purpose of collecting payment for service provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make all effort to work with companies.

To Conduct Health Care Operations

Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As result, your health information may be included in the training programs for students, interns, associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing and credentialing activities.

Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contract you to follow up on your care. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose to Federal officials or Military authorities health information necessary to complete an investigation related to public health or national Security.

Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstance, if you are a victim of crime or in order to report a suspected crime.

Family, Friends and Care givers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, where you may be unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Advancing health care knowledge often involves learning from the careful studies of health histories or prior patients. Formal review and study of health histories are a part of research study will happen only under the ethical guidance, requirement and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than what's stated above or where Federal, State, or Local law requires us, we will not disclose you health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preference from our patients.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created in our office, is not part of our records, or if the records containing your health information have been requested sealed and delivered by an authority for review.

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of you request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes. You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy right have been compromised. We encourage you to express in writing, any concerns that you may have regarding the privacy of your health information.

Patient Acknowledgement

Patient Name(s)

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

Patient

Signature _____ Date: ____/____/____