

## **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

We are required by **Federal 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 MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

A correspondence should be addressed to:

Attn: HIPAA Compliance Officer, Butler Chiropractic  
2278-C Moody Road, Warner Robins, Ga 31088



### **USES AND DISCLOSURES**

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

1. We 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. We 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. We may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.
4. We may need to use your name, address, phone number, email address, other, 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 individual, 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 providing health care services to you based on the orders (referral) of another health care provider.
2. We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

## **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)(I)
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:

- required for your treatment, to obtain payment for services, to run our practice, and/or made to you.
- necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- for national security, intelligence purposes, or law enforcement officers.
- 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, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your 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 may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave .S.W., Room 509F, HHH Bldg, Washington, D.C. 20201.

This notice is effective as of January 1, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

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**ALL INFORMATION ABOVE THIS LINE APPLIES TO YOUR FEDERAL RIGHTS PER HIPAA**

**THE FOLLOWING INFORMATION IS YOUR ASSIGNMENT OF BENEFITS AND DOES NOT APPLY TO YOUR FEDERAL RIGHTS PER HIPAA**

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand that I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

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***Patient Appreciation and Recognition Program***

"Thank You Boards," office flyers, hand-outs, office website, etc., will be used to thank patients for sharing referrals, providing testimonial, and contributing to community service programs. We list the first name with last initial only. We occasionally use photographs.

Please Initial

**Yes**, I would like to participate in the *Patient Appreciation and Recognition Program*. Thank You ☺ for initialing "**Yes**"

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I hereby authorize the doctor and whomever he/she may designate to administer Chiropractic care as he/she deems necessary to me, or my child.

X \_\_\_\_\_  
Patient's *Signature*

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Authorized Staff Person (Printed)

\_\_\_\_\_  
Personal Representative(s) (Printed)

\_\_\_\_\_  
Personal Representative(s) *Signature(s)*

Description of Personal Representative's authority to act for the patient:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_