Notice of Privacy Practices

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

We respect the privacy and confidentiality of your personal health information. This Notice describes our legal duties and privacy practices. This Notice applies to uses and disclosures we may make of all health information whether created or received by us.

1. **Uses and Disclosures of Health Information**

The following categories describe ways that we use and disclose health information.

a. **Treatment:** We may use your health information to provide you with chiropractic and related treatments. We may disclose your health information to doctors, nurses, therapists, or other personnel who are involved in taking care of you. We also may disclose information about you to other people who may be involved with your care such as a hospital, primary care physician, or other services we may need to refer you to.

b. **Payment:** We may use and disclose your health information as necessary to obtain payment for services and supplies you receive. This may also include, but not limited to, verification of insurance benefits, Medicare status, worker's compensation, accident benefits, etc.

c. **Business Administration (Healthcare Operations):** We may use and disclose your health information for our health care operations. This is necessary to ensure that all of our patients receive quality care. We also may review, internally, information about many patients to decide what additional services we should offer and whether certain new treatments are effective. We may also use information about patients for training and evaluation purposes.

2. **Other Permitted Uses and Disclosures of Health Information**

According to Federal Privacy Regulations, we may make the following uses and disclosures of your health information without obtaining written authorization from you:

a. **Persons Involved in Your Care or Payment for your Care:** We can disclose your health information to your legally appointed personal representative just as we can disclose to you. If you do not object, we may also disclose to a family member, other relative, close personal friend, or any other person you identify, health information directly relevant to that person's involvement with your health care or payment related to your health care.

b. **Our Practices:** The following are activities that may occur on a regular basis. Please review carefully. We may include your name in articles that are published in the local paper, for example, a story about an activity or special event. We may post your name on a whiteboard listing reports that are scheduled, outside referrals for other therapies or tests, or other important internal information related to your care. We will make every effort to locate this board in an area not accessible by the public and limit, as much as possible, the amount of information about your condition that we post on this board. We may also post your name on a referral board for the purpose of thanking you for referrals. We may also place your chart in a chart holder that may be in close proximity to another chart holder. We will make every effort to limit the information that may be seen.

c. **Appointments:** We may use or disclose health information to make or confirm an appointment for services. We may use the following forms of communication for the purposes of obtaining or providing communication with you: postcards, telephone calls, newsletters, text messages, emails, messages left with persons related to you or on personal answering machines.

d. **Health Related Services and Benefits:** We may use limited health information to inform you about health related benefits and services that we believe may be of interest to you. We will not use for marketing purposes unless you have given your permission.

e. **Reporting Victims of Abuse, Neglect, Domestic Violence or Exploitation:** We must disclose your health information to notify a protective services agency or government authority as required by law if we reasonably believe that you have been a victim of abuse, neglect, domestic violence or exploitation.

f. **To Avert a Serious Threat to Health or Safety:** When necessary to prevent a serious threat to your health or safety, or health or safety of the public, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.

g. **Public Health Activities:** We may disclose your health information for public health activities such as to help prevent or control disease, injury or disability, to report problems with medications or products or to advise recalls of products.

h. **As Required by Law:** We may disclose your health information when required by law to do so. This includes laws relating to worker's compensation and similar programs, such as auto insurance claims, etc.

i. **Judicial and Administrative Proceedings:** We may disclose your health information in response to a court or administrative order. We may also disclose information in response to a subpoena, discovery request or other lawful process that meets the requirements of Federal Privacy Regulations.

j. **Law Enforcement:** We may disclose your health information for certain law enforcement purposes. For example, we may disclose information to report emergencies or suspicious deaths, to identify or locate a suspect or missing person or to answer certain requests for information related to a crime. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose your health information for certain purposes including your own health and safety as well as that of others.

k. **Business Associates:** We may disclose your health information to our "business associates" who provide services (for example, legal services, consulting, etc.). If we disclose your information to a business associate, we will do so only if the business associate has agreed to keep your information confidential. They may use various forms of communication including but not limited to: dialing equipment, artificial voice or prerecorded voice, at any telephone number associated with my account, including cellular/wireless telephone numbers that may result in charges to me for the call. I expressly consent to such calls both direct and automated to my home, cellular or other associated numbers and with such consent, I specifically waive any claims I may have against all parties authorized to make such calls.

l. **Health Oversight Activities:** We may disclose your health information to a health oversight agency for activities authorized by law. For example, state or federal agencies conduct audits and inspections to assure that we, and our business associates, comply with all laws and regulations.

m. **Coroners, Funeral Directors and Others:** We may release your health information, upon your death, to a coroner, medical examiner or funeral director and, if you are an organ donor, to an organization involved in the donation of organs and tissue.

n. **National Security:** We may disclose health information to authorized federal officials as required for lawful national security activities.

o. **Active Members of the Military and Veterans:** Your health information may be used or disclosed in order to comply with the laws related to military service or veterans' affairs.

p. **Treatment and Health Related Benefits Information:** We or our business associates may contact you to provide information about treatment alternatives or other health related benefits and services that may interest you, including, for example, alternative treatment, services and nutritional supplements.

3. **Authorization**

a. Your written authorization is required for uses and disclosures not described in the categories above.

b. The authorization will describe the particular information to be used or disclosed, the name of the person or entity receiving the information, the purpose of the use or disclosure and a date or event when the authorization will expire.

c. You may revoke the previously given authorization by you at any time, but you must do so in writing. If you revoke your authorization, we will no longer use or disclose your information for the purposes specified except where we have already taken actions in reliance on your authorization. If you revoke this authorization at any time, the Practice has the right to refuse treatment. If you choose not to sign this notice, the Practice has the right to refuse treatment.

4. **Your Rights Regarding Your Health Information**

a. **Right to Request Restrictions:** You may ask us to limit the way we use or disclose your information, although we are not required to agree to what you ask except where the law makes your permission required. In addition, if you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You must submit the request in writing to the address listed at the end of this Notice. If we do agree to a restriction, we will honor that restriction except in the event of an emergency.

b. **Right to Request Communication in a Special or Alternate Manner:** You may ask us to contact you in a certain way. For example, you may ask us to send correspondence to a post office box instead of home address. We will accommodate reasonable requests. You must make requests in writing.

c. **Right of Access to Personal Health Information:** You have the right to look at or get an electronic or paper copy of your medical records and other health information we may have on you. You must submit your request in writing. We will inform you of any costs involved for copying, mailing or other services associated with your request and you may choose to modify or withdraw your request before any costs are incurred. We will provide a copy or summary usually within 30 days of the request.

d. **Right to request Amendment:** If you feel that the health information we have about you is incorrect or incomplete, you may request that we amend your health information. Your request must be in writing and must state the reason you believe the information is incorrect and are seeking an amendment or we may deny it. If we deny your request for amendment, we will give you a written denial notice explaining the reason(s) for denial. You have the right to submit a statement disagreeing with the denial and that statement will be attached to your clinical record.

e. **Right to an Accounting of Disclosures:** Beginning on May 1, 2003 and going forward, we will keep an accounting of persons or agencies we shared your health information with. We will include all disclosures except for those about treatment, payment, and health care operations. You may request, in writing, a copy of these disclosures but, we may charge a reasonable cost based fee for this service.

f. **Copy of this Notice:** You may request an electronic or paper copy of this notice at any time.

5. **Special Restrictions under State Law**

Some states have laws that provide you with more protection than the HIPAA Privacy Regulations. If this is true in your state, we will follow the law that provides you with the most protection.

6. **Our Responsibilities**

We are required by law to protect the privacy of your health information and to give you this Notice, our duties and your rights concerning your health information. We must comply with the terms of our notice currently in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time as permitted by applicable law. The new provisions will be effective for all health information we maintain, including health information we created or received before we made changes.

7. **Questions and Complaints**

If you have any complaints about the handling of your health information or would like further information about this Notice, please contact our privacy officer (Jeri Baxter) at 706-548-8984 or in writing at Chiropractic Works, 101 Cedar Rock Trace, Athens, GA 30605. You may also submit a written complaint to the Office of Civil Rights at the U.S. Department of Health and Human Services at 200 Independence Ave., S.W., HHH Building, Room 509f, Washington, DC 20201, or calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate in any way if you file a complaint.

If you have any questions about our privacy practices, please contact our privacy officer at our office.

Patient Acknowledgement of Notice to Private Practices

As required by the privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have been offered an electronic copy of the Notice of Privacy Practices that describes how my information may be used and disclosed and how I can get access to my health information. I understand the Notice may be changed at any time as permitted by applicable law. I may obtain a current paper copy of the Notice by asking the front desk personnel for one, or I can view it via my electronic access to my electronic health record.

My signature below acknowledges that I have been provided access to an electronic copy of the Notice of Privacy Practices to read.

/ /
____
Name of Patient & DOB (please print)

____
Signature of Patient or Legal Representative Date

If signed by a legal representative, relationship to patient: ____

Would you like a paper copy of the PRIVACY notice for your records? _________ Yes __________ No

Who can we release information to / speak to about your care?

Name ___________________________________ Phone ___________________ Relationship ___________________

Name ___________________________________ Phone ___________________ Relationship ___________________

Name ___________________________________ Phone ___________________ Relationship ___________________

FOR OFFICE USE ONLY

To be completed only if Acknowledment is not signed.

1) Was the patient given a copy of Notice of Privacy Practices either/and in print/electronic format? [ ] YES [ ] NO
2) Please explain why the patient was unable/refused to sign and our efforts to try to obtain signature:
____

____

Staff Name ____ Date ____