HIPAA PRIVACY POLICY/PATIENT CONSENT FORM

Promise to You our Valued Patient

We want to assure you that we take the Federal HIPAA (Health Insurance Portability & 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 office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy?

The most significant variable that has motivated 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 & 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 with the Internet, phones, fax machines & any device used to copy or transfer this data. We want to advise you that we have developed policies & procedures for our practice to assure that your personal or health information will be shared only as required & only for the purpose of administering your case. Our office is subject to State & Federal laws regarding the confidentiality of your health information. We will assure our office adherence to those laws & we want you to understand our procedures & 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 & services possible. This may include administrative & clinical procedures designed to optimize scheduling & coordination between you & all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment

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

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, & associates, as well as business & 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 & compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or 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 & make an appointment. Additionally, we may contact you to follow up on your care & inform you of treatment options or services that may be of interest to you or members of your family. 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. By my initials, I hereby consent to have my physician, Thrive 20/20, communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, appointments, insurance information and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party _____.

Public Health & National Security

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 circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends & Caregivers

We may share your health information with those you tell us will be assisting you with your home care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are 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.

Authorization to Use or Disclose Health Information

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

Patient's 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 preferences 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 & Copy Your Health Information

You have the right to read, review & copy your health information including your complete chart, x-rays & 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 & 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 & 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 by our office, is not part of our records, or if the records containing your health information have been requested sealed & or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how & 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 01/01/2015 & forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to more than six years at a time. We may need to charge you a reasonable fee for your request.

Open treatment Areas

Some treatments are performed in public spaces with other patients, staff, contractors, interns & volunteers present. You may at any time refuse treatments or ask for a private space for treatments, but additional waiting time may be required to fulfill this request. If a treatment cannot be performing in privacy, you may refuse to undergo that treatment & we will work to find other treatment options. We find that open treatment spaces improve care by facilitating interaction between people suffering from similar conditions. We recognize that this provides a forum between patient to discuss additional healing, treatment & management strategies.

Request a Paper Copy of this Notice

You have the right to request & obtain a copy of the Notice of Privacy Practices directly from our office at any time. We are required by law to maintain the privacy of your health information, & to provide to you & your representative this Notice of our Privacy Practices. We are required to practice the policies & 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 & Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed & understand this policy & intend this consent form to cover the entire course of treatment for the present condition & for any future condition(s) for which treatment is sought at Thrive 20/20, a Kauffman Chiropractic, Inc.

To be completed by patient's legal representative (***if required***)

_____

Print Name of Patient's Legal Representative/ Guardian /Parent

X_____

Signature of Patient's Legal Representative Date Signed

To be completed by patient:

Print Patient's Name

X

Signature of Patient Date Signed