

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

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

### **Uses and Disclosures**

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

- 1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
- 4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, 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. 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.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. 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.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

### **Our Privacy Pledge**

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

### **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 these following circumstances:

- 1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
- 2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
- 3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

***Notice of Privacy Practices for Protected Health Information***

- 4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- 5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

**Your right to revoke your authorization**

You may revoke your authorization to us at any time; however, your revocation must be 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. If you wish to revoke your authorization please write to us at

\_\_\_\_\_  
*Bauer Chiropractic & Muscle Therapy*  
\_\_\_\_\_  
*306 W. Cook Street*  
\_\_\_\_\_  
*Portage, WI 53901*  
\_\_\_\_\_

**Your right to limit uses or disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

**Your right to receive confidential communication regarding your health information**

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

**Your right to inspect and copy your health information**

You have the right to inspect and/or copy 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 your request to inspect and/or copy your health information to be in writing.

## *Notice of Privacy Practices for Protected Health Information*

### **Your right to amend 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 your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

### **Your right to receive an accounting of the disclosures we have made of your records**

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. 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.

### **Your right to obtain a paper copy of this notice**

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

### **Our duties**

We are required by 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.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

### **Re-disclosure**

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.



## PATIENT HEALTH INFORMATION CONSENT FORM

### ***Our Privacy Pledge***

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our *Privacy Notice*, please understand that we have and always will respect the privacy of your health information. At your request we will give you a copy of our *Privacy Notice*. Bauer Chiropractic & Muscle Therapy, does reserve the right to change our privacy practices as described in the notice. If any future changes are made to our privacy practices, we will notify you in writing.

### ***Consent for Use or Disclosure of Health Information***

The following are possible circumstances in which we may have to use or disclose your PHI (Patient Health Information);

We may have to disclose your PHI to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.

We may have to disclose your PHI and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your PHI within our office for quality control or other operational purposes.

Initials: \_\_\_\_\_

### ***Appointment Reminders and Health Care Information Authorization***

Authorized staff of Bauer Chiropractic & Muscle Therapy may need to use your name, address, phone number, billing information and your clinical records to contact you with appointment reminders, information about treatment alternatives or other PHI. Contact may be attempted through three methods; mail, email, or phone. If this contact is made by phone and you are not home, a message will be left on your answering machine or voice mail. By signing this form, you are giving us authorization to contact you in this manner. As well, you may restrict the individuals or organizations to which your PHI is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. In addition, your authorization to give us your PHI allows us to disclose that information to your insurance company for benefit verification or claims processing. You have the right to refuse to give us this authorization. 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.

Permission to call at work:  YES  NO

Initials: \_\_\_\_\_

### ***Wisconsin Chiropractic Association Authorization (WCA)***

Authorized staff of Bauer Chiropractic & Muscle Therapy may also need to disclose your name, address, phone number, billing information and your clinical records to the WCA. Due to possible problems with improper insurance claims processing or for assistance in receiving reimbursement for our services to you, your PHI may need to be disclosed to the WCA with your authorization. By signing this form you are giving us authorization to send the WCA your PHI. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. You may restrict the individuals or organizations to which your PHI is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide or the methods we use to obtain reimbursement for your care.

Initials: \_\_\_\_\_

### ***Marketing Authorization***

From time to time our office may mail you information to make you aware of special offers related to products or services, and events that may interest you. Your authorization is required to market the following products and/or services to you; Thank You Cards, Birthday Cards, Get Well Cards, Holiday Greeting Cards, Congratulations cards, Patient Appreciation Day Announcements, Newsletters, Coupons, Brochures, Surveys, Food Drives, Charity Organizational Drives or products from Foot Levelers and USANA Health Sciences. We may put patient names on a Patient Orientation Attendance Board until requirements are met. We may thank our patients for their referrals by putting their name on a "Thank You" Board.

Initials: \_\_\_\_\_

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules. This notice is effective as of 07 / 01 / 2006 and will expire seven years after the date on which you last received services from us.

Initials: \_\_\_\_\_

I authorize you to use or disclose my health information in the manner described above. I have read this consent form and agree I am also acknowledging that I have received a copy of this consent form.

Patient Name (Signature) \_\_\_\_\_ Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Authorized Provider Representative (Signature) \_\_\_\_\_ Date \_\_\_\_\_