

SCHROEDER CHIROPRACTIC P.C.

A Family Wellness Center

207 E. WALL STREET HARRISONVILLE, MO 64701 Tel:(816) 380 6699 Fax: (816) 884 3432

Notice of Privacy Practices

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

The misuse of Private Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all our employees and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis to the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in anyway to the growing problem of improper disclosure of PHI. As part of this plan we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

In the course of your care as a patient, we may use or disclose personal and health related information about you in the following ways:

Your personal health information, including your medical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer (this is done only if they are or may be responsible for the payment of your services.)

We use a sign-in sheet at the reception desk where you will be asked to write your name and we will call you by name when we are ready to see you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to provide other health related information that may be of interest to you. We may also call you to inquire about your health and well-being, if you interrupt your care for a period of time.

If you are not at home when we attempt to call you, we may leave a message on your answering machine. You have the right to refuse that we contact you regarding these matters. Your refusal will not affect the care provided to you or the reimbursement avenues associated with your care. Please inform the chiropractic assistant if you do not want us to call you.

Any use or disclosure of your protected health information, other than the exceptional circumstances outlined in the examples listed below, will only be made upon your written 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:

If we are providing health care services to you based on the orders of another health care provider.

If we provide health care services to you in an emergency, and you are not able to give us consent.

If there are substantial barriers to communicating with you, but we believe, in our professional judgement that you intend for us to provide the care.

If we collaborate with public health authorities for the purpose of controlling diseases, injuries or disabilities.

If we are ordered by the courts or other appropriate agencies.

We normally provide information about your health care to you in person at the time you receive chiropractic care in our Health center. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like this information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or obtain a copy of your health information for seven years from the date the record was created or for as long as the information remains in our files. (Copy of records will be prepared within three business days and you will be charged a reasonable and customary cost for this service).

In addition you have the right to request an amendment to your health information. Request to inspect, copy or amend your health information should be provided to us in writing. (Ask our chiropractic assistant to provide you with the appropriate request form).

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

Furthermore, we are required to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. Should any change be made, you will be notified in writing as soon as possible. Any change in our privacy notice will apply to all the health information contained in your file.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you may ask the doctor for a complaint form.

Notice: Our Health Center utilizes an open treatment area for our therapy modalities and our rehabilitation exercises. An open area may result in several patients being cared for in the same room at the same time, and some ongoing details of your care may be discussed and heard by other patients and staff. This environment is not used for history, examination and report of findings, which are completed in a private, confidential setting. If you are concerned about the privacy of your health information in an open treatment area, please ask to avoid discussing your condition in this environment, and to take you to a private room after the therapy session for further discussion about your care.

If you would like further information about our privacy policies and practices, please contact Linda Donley.

This Notice of Privacy Practices is effective as of July 26th, 2004

This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I had the opportunity to read this notice.

Name (Please Print)

S i g n a t u r e
D a t e

For a minor or person represented by another party.

Name of personal representative (Please Print)

S i g n a t u r e
D a t e

Description of the authority to act on behalf of the patient (Parent, guardian....)