HIPAA Notice of Privacy Practices

Injury Chiropractic
7333 W. Thomas Road, Suite 40
Phoenix, Arizona 85033
(623) 849-1736

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office at 623-849-1736.

PLEASE GIVE THE PATIENT A COPY OF THIS NOTICE

INJURY CHIROPRACTIC ❑ **-CASH** ❑ **-HEALTH**

PATIENT INFORMATION: Male / Female

Name: _____ Date of Birth: _____ Age: ____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip : _____ Driver's License #: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Employer: _____ Occupation: _____

RESPONSIBLE PARTY: *If the patient is a minor or if someone else is responsible for payment, please complete this section.*

Name: _____ Date of Birth: _____ Age: ____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip : _____ Driver's License #: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Employer: _____ Occupation: _____

EMERGENCY CONTACT INFORMATION: Relationship: _____

Nearest Relative's Name: Home #:( )

PRIMARY HEALTH INSURANCE INFORMATION: ID# : _____

Insurance Company: _____ Insured's Date of Birth: _____

Insured's Name: _____ Relationship: Self Spouse Parent Other

Insurance Phone #: (_____)_____

AUTHORIZATION & ASSIGNMENT OF BENEFITS: I, the undersigned patient and/or responsible party, authorize Injury Chiropractic Center (the "Center") to release any medical records and billing information to the insurance company. In addition, I authorize and assign appeal rights to the Center. Finally, I authorize, assign and direct the insurance carrier to directly reimburse the Center for services provided now and hereafter.

CONSENT TO TREAT & FINANCIAL RESPONSIBILITY: Chiropractic care is a non-invasive approach with some of the safest outcomes in health care. I understand that the Center cannot promise a complete recovery but will provide the best care possible and address any concerns. Furthermore, I have been advised I may experience temporary symptoms like soreness following manipulation or traction and skin irritation after ice, heat, ultrasound or EMS. I am aware that in rare instances, manipulation can cause aggravation to bulging/ herniated disc or cause a rib fracture, and even more rarely, cervical manipulation can be related to compromised vertebral artery and possible stroke symptomatology. Understanding the limitations and possible complications of receiving chiropractic care, I hereby authorize the Center to examine, take x-rays and provide treatment that is deemed medically necessary for my condition or my minor child's condition.

Furthermore, I agree that health insurance policies are an arrangement between the insurance carrier and the insured. Even though I authorize insurance carriers to assign benefits directly to the Center, I clearly understand and agree that all services are charged directly to me and I accept personal responsibility for payment of said services. I understand that expenses not covered by insurance are my responsibility for payment. In addition, I understand that if the Center must employ collection counsel and/or legal counsel to obtain payment for my debt, I will be responsible for any and all collection fees, interest fees and reasonable attorney's fees.
My signature below confirms that I understand and agree to comply with all parts of this document.

_____ _____

Responsible Party Signature Date Signed

_____ _____

Print Responsible Party Name Print Patient's Name (if minor)

REASON FOR YOUR VISIT:

- Describe your current problem or symptoms: _____

When did you first begin having problems? _____

Are your problems related to a work injury, auto accident or other accident? ❑ YES ❑ NO

List all other doctors you have seen for this problem: _____

Are there any activities that make your pain worse? _____

Does your current problem interfere with: ❑ Work ❑ Sleep ❑ Daily Activities

Have you lost any time from work due to your problem? ❑ YES ❑ NO Last day worked: _____

Describe what type of compensation you are receiving, if any, for time lost from work: _____

- Are your symptoms currently: ❑ Improving ❑ Getting Worse ❑ Remaining the Same

PAST MEDICAL HISTORY:

List any previous illness that may relate to your current problem.

_____

- List any congenital (from birth) factors that relate to your current problem. _____
- List and describe any previous accidents and include the date of injury and type of injury below.

_____

List and describe any treatment you received by a physician for any health condition in the last year.

_____

HIPAA PRIVACY PRACTICES: On a separate form, our office has supplied you with a copy of our office's HIPAA Notice of Privacy Practices. By signing below, you only acknowledge that you have received a copy of this Notice.

_____ _____

Patient or Responsible Party's Signature Date