HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully. HIPAA – Health Insurance Portability and Accountability Act

Our Promise To You our Valued Patient….

This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal HIPPA (Health Insurance Portability and Accountability Act) law seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?

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 and protect the electronic exchange of your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding confidentiality of your health information. We will assure our adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. *Be assured that without your written permission, your health information will not be used for any other purpose.*

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 and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentations procedures will enable us to provide information your health information usage from January 2, 2006 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide you and your representatives this Notice of our

Privacy Practices. We are required to practice the policies and 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 immediately.

You have the right to express concerns or complaints to us or the Secretary of Health and 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.

At our office, we believe in the importance of patient contact and do our best to maintain proper communication to better the patient experience. I hereby give my permission to receive any form of communication from Stinson Chiropractic Center regarding any billing information, mailings, postcards, phone calls and text messages coming into and out of the office.

Patient Acknowledgement

Patient Name (s):

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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 and understand this policy.

_____ Date _____/_____/_____

Patient Signature

Thank You For Your Trust and Confidence