Vital Life Chiropractic

811 Disk Dr. Rapid City, SD 57701
3103 E Fairground Loop #1 Spearfish, SD 57783

Notice of Privacy Practices

Your Rights & Our Responsibilities

EFFECTIVE: March 1, 2020

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 PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical health condition and related health care services. **Please review it carefully.**

Your Rights

This section explains your rights and how we are required to acknowledge them.

Request a copy of your paper or electronic medical record

- Upon request, we will supply you with a *Request to Inspect or Copy Patient Information form*. The form contains the name of our privacy official and his/her contact information.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee for cost of labor, postage, and supplies associated with your request (in compliance with state and federal laws regarding medical records request). We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

Receive a paper copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Request correction of your medical record

- Upon request, we will supply you with the *Request to Amend Patient Record form*.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request; our response will be in writing within 60 days.

Request confidential or alternative communication

- Request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by email.
- Request alternative communications; you must make your request in writing to our privacy office, a *Request for Alternative Communications* form will be provided upon request.

Ask us to limit the information we share

- List individuals who are involved in your care and as a result PHI can be disclosed; a *PHI Use and Disclosure Authorization Form* will be provided, upon request.
- Restrict payer access. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You must make your request in writing to our privacy office; a *Request to Restrict Disclosure to Health Plan Form* will be provided upon request.

Receive a list of those with whom we've shared your information

- You have the right to request an accounting of disclosures of your health information made by us. We are not required to list certain disclosures, including: disclosures made for treatment, payment, and health care operations purposes (TPO).
- You must submit your request in writing, a *Request for Accounting of Disclosure of PHI Form* will be provided upon request. The first accounting of disclosures (*Response to Request for Disclosure Form*) you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures.

Right to Receive Notice of a Breach

- We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.

File a complaint if you believe your privacy rights have been violated

- If you believe your privacy rights have been violated, you may file a complaint with our privacy officer; we will supply you with a *Complaint Form* upon request (form contains the name of our privacy official and his/her contact information).

- All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

This section addresses your choices regarding health information we may share.

You have the choice to tell us to:

- Share information with your family and friends about your condition.
- Disclose your health information when disaster relief organizations seek your health information to coordinate your care. Note: If you are unable to communicate your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.

We will never share your information in these cases without permission:

- Marketing purposes. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.
- Sale of your information. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization

Our Uses and Disclosures

This section lists ways in which we may use your information and disclose it.

Healthcare Treatment

- Plan your care and treatment, including preauthorization and pre-certification.
- Communicate with other providers such as referring physicians.
- Billing and coordination of payment for services with health plan administrator.
- Quality and outcome assessments for improvement of care we render.
- Contracted third-party business associates for services, such as answering services, transcriptionists, record keeping, consultants, and legal counsel.
- Communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Public Health and Safety Issues

- Product recalls
- Reporting suspected abuse, neglect or domestic violence in compliance with state and federal laws.

Compliance with the law

- Department of Health and Human Services investigations for complying with federal privacy laws.
  Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions such as a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law.
  If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

Other

- Text reminders
- Product offers
- Medical tips and suggestions

Clinic Contact Information:
605.791.3222

Our Responsibilities

- If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information.
  We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.
- To provide you with notice, such as this Notice of Privacy Practices and abide by the terms of our most current Notice of Privacy Practices.
- Notify you if we are unable to agree to a requested restriction.

Changes to the Terms of this Notice

- We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change; a revised *Notice of Privacy Practices* will be available upon request. We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices*. If you have limited proficiency in English, you may request a Notice of Privacy Practices in Spanish.

Vital Life Chiropractic
811 Disk Dr Suite 101
Rapid City, SD 57701

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of *Vital Life Chiropractic's Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____
(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____Drivers License Number: _____State____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____Date _____ Staff: _____

Attempt 2: _____Date _____ Staff: _____

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Vital Life Chiropractic disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____ /____ /____

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Vital Life Chiropractic in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Vital Life Chiropractic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

_____ _____

Signature of Personal Representative Date

Relationship to Patient: _____Drivers License Number: _____State____