Mason Wellness Center

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.

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

*** Your personal health information, including your clinical 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 (if they are, or may be responsible for payment of your services.)**
*** Your name, address, phone number, and health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your personal care, or to other health related information that may be of interest to you.**

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. You have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

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.**
***If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.**
*** If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend us to provide care.**
*** If we are ordered by the courts or another appropriate agency.**

Any use or disclosure or your health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account.

Matt S. Mason, D.C.

2630 Layer Rd. S.W.
Warren, Ohio 44481

Phone 330-219-6250
Fax 330-469-9285

If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We require by state and federal law 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. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health information in our files.

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

Patient authorization for contact regarding Chiropractic care, laboratory tests, related health services, scheduled appointment related issues.

It is our desire for our staff to use your name, address and or telephone number for the purposes of contacting you or to remind you about scheduled appointments, re-evaluations or other appointment, and related issues. It will also be used for the purpose of contacting you to advise you about health meetings, workshops, products, and newsletters.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect or our privacy activities you should direct you're complaints to our office. (330) 219-6250

This notice is effective as of _____. This notice, and any alteration or amendments made here to will expire seven years after the date upon which the record was created.

I have had full opportunity to read and consider the contents of this Notice of Privacy Practices consent form. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care options.

_____	_____	_____
Name (printed)	Signature	Date

If you are a minor, or you are being represented by another party

_____	_____	_____
Name (printed)	Signature	Date