LUDWIG CHIROPRACTIC CENTER, P.S.

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for the covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one of more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a chiropractic plan for your chiropractic care.

Health Care Operations include the business aspects of running the practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed on the Acknowledgment Form.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 16th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address found on the Acknowledgment Form, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

19950 S. PRAIRIE RD. E BONNEY LAKE, WA 98931 PH 253·735·0123 FAX 253·735·0759

LUDWIG CHIROPRACTIC CENTER, P.S.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it.

Adjustment: An adjustment is the specific application of forces using the doctor's hands and/or a hand-held Activator® chiropractic instrument to help the body in the correction of a spinal or other joint misalignment.

Spinal Subluxation: is a neurological imbalance or distortion in the body which inhibits the body's ability to function properly and express maximum health. The most frequent site for the chiropractic correction of subluxation is via the vertebral column but may also involve other joints of the body.

Health: A state of optimum physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not diagnose or treat disease conditions other than vertebral subluxations. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If we believe your case is not a chiropractic case, we will inform you of that.

I,_____ have read and fully understand the above statement.
(Print name)

I voluntarily and knowingly request and consent to services which can or will include consultation, examination, evaluation, chiropractic treatment and other diagnostic tests as well as possible referral for imaging studies (x-rays, MRI etc.) as deemed appropriate by Dr. Ludwig. I am aware that the practice of chiropractic, as in medicine and surgery, is not an exact science and I acknowledge that no guarantees have been made to me as to the results of care, treatment or examination. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) **(Date)**

Health Insurance Portability and Accountability Act (HIPPA) Acknowledgement Form

The notice of Privacy Practices has been presented to me and I have been provided an opportunity to review it.

Name_____

Signature_____ **Date**_____

For more information please contact:
Ludwig Chiropractic Center
19950 S. Prairie Rd. E
Bonney Lake, WA 98391 253-735-0123

For more information about HIPPA or to file a complaint:
The U.S. Dept. of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201 877-696-6775 (toll free)