NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This notice takes effect April 14, 2003 and remains in effect until we replace it.

OUR PLEDGE REGARDING CHIROPRACTIC AND MEDICAL INFORMATION:

The privacy of your chiropractic and medical information is important to us. We understand that your information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share health information about you. We also describe your rights to certain duties we have regarding the use and disclosure of health information.

OUR DUTY:

Law Requires Us to:

1. Keep your chiropractic and medical information private
2. Give you notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have The Right to:

1. Change our privacy practices and the terms of notice at any time, provided that law permits the changes.
2. Make changes in our privacy practices and the new terms of our notice is effective for all chiropractic and medical information that we keep, including information previously created or received prior to the changes.

Notice of Change to Privacy Practices:

1. When we make an important change in our privacy practices, we will notify you in writing as soon as possible, following those changes. Any changes in our policy notice will apply to all your health information in our file.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION:

The following describes the different ways that we use and disclose chiropractic and medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your chiropractic and medical information for any purpose not listed below without your specific written authorization unless we are required to do so by law. Any specific written authorization you provide may be revoked at any time by writing to us.

CARE AND SERVICES: Inter-office use of PHI (**P**ersonal identifiable **H**ealth **I**nformation) to determine the best course of care in your individual situation. We may disclose PHI to other providers of services when diagnostic or evaluation outside our office becomes necessary or to otherwise assist in your care.

PAYMENT: PHI may be used for the purpose of billing and collection of payment for services rendered. This disclosure may include communication with third party payers including but not limited to insurance carriers, family members responsible for payment, attorney offices. We may disclose your PHI to agencies assisting in the collection process.

OPERATIONS: Business operations may include disclosure of PHI. Examples may include but are not limited to - internal quality assurance evaluation, patient communication (non-care oriented - i.e.: Birthday and Holiday greetings condolences, special occasions, health information, office calendar / schedule, appointment reminders). We may use PHI to contact you regarding your appointment schedule or regarding your care, should you not be available a message may be left regarding your appointment. We operate as an Open Door Practice design. Due to the open environment we cannot insure absolute confidentiality of verbal communication. Should you wish to discuss a confidential matter with us, a private confidential area can be made available. Emergency situations may occur which require release of information. Advise us in writing should you not desire any of the specific services of our operations.

SPECIAL CIRCUMSTANCES: We will use and disclose your PHI when we are required to do so by federal, state or local law.

YOUR RIGHTS REGARDING YOUR PHI:

CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you in a specific manner regarding phone and written communication. You must make such specific requests in writing though no reason is needed for your request. We will accommodate reasonable requests.

REQUESTING RESTRICTIONS: You have the right to request a restriction in our use and / or disclosure of your PHI. **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.** However, if we agree we are bound by our agreement except if otherwise required by law, emergencies, or for purposes of rendering care. Any and all requests must be made in writing. All requests must describe in a clear and concise fashion: a) the specific information you wish restricted, b) whether you are requesting to limit our practice use, disclosure or both, and c) to whom you want the limits to apply.

INSPECTION AND COPIES: You have a right to inspect and obtain a copy of your PHI. Any and all requests to either inspect or obtain must be made in writing. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

AMENDMENT: If you believe your PHI is inaccurate or incomplete you may ask us to amend it. Such an amendment will be kept for as long as your PHI is maintained by our practice. To request an amendment, your request must be submitted in writing including a reason that supports your request for amendment. Our practice will deny any request which is not made in writing, or if you request that we amend information that is in our opinion: a) accurate and complete, b) not part of the PHI created by and for our practice, c) not part of the PHI which you are permitted to inspect or copy. You have the right to respond to denials with a statement of disagreement, which will be added to your records.

ACCOUNTING OF DISCLOSURES: All patients have the right to request an "accounting of disclosures" - a list of all non-routine disclosures our practice has made of your PHI not related to care, payment or operations. Use of your PHI as part of routine care and/or operations in our office is not required to be documented. Requests for this information must be submitted in writing and include a time period, which may not exceed 6 years from the date of disclosure or be prior to April 14, 2003. The first request in a 12-month period is free of charge; any additional requests in a 12-month period will incur a charge. You may withdraw your request for additional requests before fees are incurred.

RIGHT TO A PAPER COPY OF THIS NOTICE: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our office in writing.

RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, submit complaint in writing to our office. **You will not be penalized for filing a complaint.**

RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USE AND DISCLOSURES: Your written authorization will be obtained for any use or disclosures not identified by this notice or required or permitted by law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time **IN WRITING.** After your written revocation of authorization, we will no longer use or disclose your PHI for the reasons described in the authorization unless required by law.

ALL WRITTEN REQUESTS ARE TO BE SUBMITTED TO:

PRIVACY OFFICER / SECURITY OFFICER
BILL ROMICK
TLC FAMILY CHIROPRACTIC
3225 B RIDGEWOOD AVENUE
S. DAYTONA, FL 32119

As required by the Health Information and Portability and Accountability Act of 1996, my signature acknowledges that I have received a copy of this Notice of Privacy Practices.

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Name (Printed)

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Patient or Guardian Signature **Date**

Signature Refused:_______________________________________**(Security Officer) Date:**____________________