

NOTICE OF PRIVACY PRACTICES

A WAY OF WELLNESS CHIROPRACTIC

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Bloomington, IN 47403
(812)336-2225

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE NOTICE CAREFULLY.

This Notice of Privacy 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 or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosis and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information is requires to provide you with effective treatment.

Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provide to you. For example, we may contact your health insurer to verify you eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations: We may use disclose you health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and other like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper, or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional request within the same period, we may charge you for the reasonable cost of providing the accounting of disclosures. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for you care. You have the right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree. We will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restriction, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, weather you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to 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 e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable request.

Effective Date: January 1, 2022

Dr. Pitcher & Dr. Gray

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 e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

COMPLAINTS

If you believe your privacy rights have been violated you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. 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.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Notice of Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not acted in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

By signing the Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature: _____ Date: _____

Print name: _____