File # _____

Seminole Heights Chiropractic & Wellness
REVITALIZING HEALTH. ENHANCING WELLNESS.

Clinic: 813-944-9933 | **215 E. Sligh Ave Tampa, FL 33604**
Fax: 888-975-8721 | Email: info@seminoleheightschiropractic.com

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice describes how medical information about you may be used and disclosed and you can get access to that information as required by 45 CFR 164.520.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. This Notice may be amended or revised at which time you will be provided the revised or amended Notice to review.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) Any information is deleted that would identify you.

(b) To a company or person who is not employed by the practice to provide a service such as billing insurance and/or electronic records. These persons/companies are called “Business Associates.” Only that information necessary to perform the service will be submitted to the business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

(c) To a person that you designate as a personal representative who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations:

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Appointment reminders are used by the Practice. The Practice will use those methods which you designate at the end of this Notice, such as: a) a postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone; or sending you an email or text message.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION OF PHI

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be

permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850 414-3300 if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, **DR. ROBERT BRADLEY KOSER JR, DC**, at **813-944-9933** or via email at **INFO@SEMINOLEHEIGHTSCHIROPRACTIC.COM**.

PRACTICE'S REQUIREMENTS

1. The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:

Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases, Section 456.057 relating to patient records ownership, control and disclosure and Section 501.171 relating to protecting your personal information, Social Security and driver license numbers, credit or debit card information, financial accounts information, email address, and medical information.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

ELECTRONIC TRANSFER OF PROTECTED PATIENT INFORMATION PRIVACY PRACTICE

SEMINOLE HEIGHTS CHIROPRACTIC & WELLNESS seeks to protect the privacy of Protected Health Information stored on computer(s) of the SEMINOLE HEIGHTS CHIROPRACTIC & WELLNESS or transmitted via the internet.

Only authorized employees shall have access to computers on which Protected Patient Information is stored. All computers will be protected with a password. Only authorized employees may use a password to access computers. The password will be periodically changed and changed any time an authorized employee leaves the Practice's employ.

Only the owners of the practice will be authorized to take out of the Practice's premises back up discs or flash drives onto which Protected Patient Information has been copied. The owner will take appropriate steps to protect the information on the discs or flash drives from unauthorized disclosure. Back up data will be stored in a secure place.

Any electronic claims that may be filed using software that is approved for electronic transmissions of Protected Health Information and which protects the privacy of such information as it becomes available.

The Practice will make certain that any billing services used by the Practice to electronically file claims on behalf of the Practice have a policy adopted that protects Protected Health Information and that uses software that is approved for electronic transmissions of Protected Health Information and which protects the privacy of such information.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below whom is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is **DR. ROBERT BRADLEY KOSER JR, DC**.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

RESEARCH

This clinic may need information in your medical records for a research study with your written consent. For example, we may need to know your medical diagnosis or know about allergies you may have. The clinic may also need to collect health information about you from other health care

providers because the information may be important to the study. For example, the research team may need to get your lab test results from your doctor.

Selection for participation in a research study is based on very specific criteria. You will need to give additional authorization to participate. This authorization will tell you:

- Who will use, share and receive your personal information;
- What personal health information is needed for the research study;
- Why your personal health information will be used or shared;
- Your right to change your mind and cancel your authorization at any time; and
- Information on what happens if you do not sign the authorization form, and how long your information will be used or shared.

The HIPAA privacy rule permits us to communicate with you regarding your health care. We will notify you by phone if we have to change, alter or cancel your scheduled appointment. Appointments are considered part of our treatment. Authorization or permission to call is not required. HIPAA allows a message to be left on an answering machine, voice mail or with a third party. Information will be limited to no more than necessary.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

MARKETING

From time to time, our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. We may need to use your health information including your name, address, telephone number, and your clinical records for the purpose of marketing products or services to you. The authorization form you sign for this purpose contains the name of the organization and/or the products and services we are marketing.

You have the right to refuse to give us authorization to contact you for marketing purposes. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to market products and/or services to you at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

FUNDRAISING

From time to time, our practice raises money for charitable causes. We may need to use your health information including your name, address, telephone number, and your clinical records to contact you to request your assistance with these fund raising efforts. The authorization form you sign for this purpose contains the name of the organization(s) for whom we are raising money.

You have the right to refuse to give us authorization to contact you for fund raising purposes. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you about fund raising efforts at any time. Our practice and staff will receive direct or indirect remuneration from our fund raising activities.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [**patient's name**] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Seminole Heights Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Dated: _____

Patient's Printed Name: _____

Patient's Signature: _____

Signature of Parent or Guardian (if the patient is a minor): _____

By checking the boxes below, I authorize being contacted for practice/appointment reminders by:

Mail	❑ **YES**	❑ **NO**
Email:	❑ **YES**	❑ **NO**
Phone:	❑ **YES**	❑ **NO**
Voicemail:	❑ **YES**	❑ **NO**
Text:	❑ **YES**	❑ **NO**

AUTHORIZATION OF PERSONAL HEALTH INFORMATION (PHI)

List below the names and relationship of people to whom you authorize the Practice to release PHI.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.