Lacerda Chiropractic
17295 Monterey Rd.
Morgan Hill, CA, 95037 Phone number - 408/779-3176

FOR THE REMAINDER OF THIS AGREEMENT THE ABOVE PRACTICE NAME WILL SIMPLY BE CALLED "CLINIC".

CLINIC NOTICE OF PRIVACY AGREEMENT

THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH INFORMATION AT THE CLINIC MAY BE USED OR DISCLOSED. ALSO HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW THIS CAREFULLY.

CLINIC is required, by law, to maintain the privacy and confidentiality of YOUR protected health information and to provide YOU our PATIENT with a NOTICE of our legal duties and privacy practices with respect to YOUR protected health information.

CLINIC NOTICE OF PRIVACY AGREEMENT DEFINITIONS:

- PATIENT, YOU or YOUR shall mean the same as the person named

  below: ____
  (Patient Name)

  which shall in the future simply be called "PATIENT".
- CLINIC shall mean the same as the above CLINIC's name.
- "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E of the 1996 HIPAA.
- "CLINIC NOTICE OF PRIVACY AGREEMENT" shall mean the same as "Agreement" meaning this specific agreement.
- "NOTICE" shall mean the same as "CLINIC NOTICE OF PRIVACY AGREEMENT" also meaning this specific agreement.

■ DISCLOSURE OF YOUR PROTECTED HEALTH CARE INFORMATION

- TREATMENT RECORDS:
  1. YOUR private health information may be used in the CLINIC by all CLINIC doctors, for the purpose of treating YOU on a day-to-day basis.
  2. If we need to refer YOU to another doctor outside the CLINIC it may be necessary to provide them with YOUR protected health information.
  3. From time to time YOU may be treated by a substitute doctor of the CLINIC's choosing. In those instances YOUR protected health information would be shared with that doctor with out advance permission or NOTICE. This could happen If YOUR treating doctor is sick, or unavailable, or on vacation or other emergencies.
- PATIENT PAYMENT RECORDS.
  1. In order to get YOUR bill paid, we will disclose YOUR private health information as is required by YOUR insurance companies to get YOUR bill paid at the CLINIC. Included in this information will be a diagnosis of YOUR condition, treatment dates, injury or health condition dates of onset, and specific billing codes that describe the type of care YOU received at the CLINIC.
  2. If YOU are a Worker's Compensation PATIENT by law the CLINIC must disclose any of YOUR private health information.
- EMERGENCIES
  1. In the event there is an emergency that involves YOU our PATIENT, the CLINIC may disclose YOUR private health information to a family member or YOUR legal guardian. This may include YOUR medical emergency condition or death.
- PUBLIC HEALTH OFFICIALS

  The law requires that the CLINIC must disclose YOUR protected health information to public officials in the following situations:
  1. In the prevention or controlling communicable diseases.
  2. Reporting suspected domestic violence or child abuse or neglect.
  3. Reactions to prescribed drugs - To the Food and Drug Admin.
  4. Judicial proceedings - Judges
  5. Law enforcement agencies - that deal with locating fugitives, witnesses or missing persons. Complying to a court order or a subpoena.
  6. Coroners or medical examiners

7. Organization involved in getting or banking transplant organs - if YOU die.
8. Research required by law to report in association with the Institutional Review Board.
9. Public Safety Officials - in instances where the public's health or safety may be jeopardized.
10. Special government agencies such as the military, national security or prison authorities.
11. Appointment Reminder Calls - We will not leave messages on YOUR answering machines.
12. CLINIC sale - If the practice is sold to another doctor YOUR private information becomes the property and the responsibility of the new owner.

■ YOUR RIGHTS AS DESCRIBED THE THE 1996 HIPAA ACT:

- YOU have the right to put certain restriction on how the CLINIC uses and discloses YOUR private health information. The CLINIC does not have to agree to the restriction in certain situations.
- YOU have the right to have the CLINIC send all mail to YOU at a different address than where YOU live. YOU must simply request it.
- YOU have the right to look at all YOUR health information files that the CLINIC has. YOU have the right to get a copy of any of YOUR health information.
- YOU have the right to request a change in any of the chart notes or information in YOUR health information files. The CLINIC can by law not comply with YOUR requested change to health information. The CLINIC however, must give YOU a written response as to why it does not want to change YOUR health information record. Also CLINIC will tell YOU how YOU can disagree with the denial.
- YOU have the right to have the CLINIC show YOU all people or places that YOUR protected health information has been sent to.
- YOU have the right to have a copy made of this Notice of Privacy Practices at anytime YOU ask for it.

■ FUTURE CHANGES TO THIS NOTICE OF PRIVACY AGREEMENT

- CLINIC can change this NOTICE at any time. This NOTICE will continue to be in force until new changes have been made. Anytime changes are made to this NOTICE, CLINIC is required by law to have YOU sign a new copy and then give YOU a copy.
- If YOU have any questions about this NOTICE or any questions about YOUR protected health information please discuss this with CLINIC's Security Officer. Also feel free to call our CLINIC at the number mentioned at the top of this Agreement and make an appointment to discuss this NOTICE. We will make an appointment for YOU for a personal phone call or in person conference with in 2 working days.

■ COMPLAINTS ABOUT THE CLINIC'S PRIVACY POLICIES OR PROCEDURES

- Any complaint about how the CLINIC has handled YOUR private health information should be directed to the CLINIC's Privacy Officer. YOU can call the CLINIC at the above phone number and the CLINIC will make an appointment with YOU to discuss YOUR concern with in 2 working days.
- If YOU are not satisfies with how the CLINIC handles YOUR complaint YOU can send a formal complaint to:

  DHHS, Office of Civil Rights
  200 Independence Avenue, S.W.
  Room 509F HHH Building
  Washington, DC 20201

■ RESTRICTIONS OR CHANGES OF YOUR PRIVATE HEALTH INFORMATION OR CHANGE OF MAILING ADDRESS OR PHONE NUMBER, FAX NUMBER OR E-MAIL. IF YOU WISH TO:

- "Request for a Restriction" of my Protected Health Information.
- Change where the CLINIC sends YOUR mail.
- Change where the CLINIC communicates to YOU by phone or fax or e-mail.
- wish to object about the "Notice of Privacy Agreement".

Simply ask any of our CLINIC employee for the form to do so.

■ PATIENT AUTHORIZATION REGARDING CHIROPRACTIC CARE BEING PROVIDED IN AN "OPEN-DOOR" ADJUSTING ENVIRONMENT

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking personal patient histories or performing personal examinations. These procedures are completed in a private, confidential setting.

It is the procedure of the CLINIC to present a group report of findings were other new patients are present. At this group report of findings the material presented there is common information about the spine and general health information which is not personal, nor any way the patient's private health information. After a group report of findings an personal report of findings will be given to each new patient, where personal and private information will be given only to the patient and their spouse.

We are requesting this authorization of YOU due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters. In the event YOU or someone else would not agree with us, we are providing this disclosure and requesting YOUR authorization.

The use of this format is intended to make YOUR experience with our office more efficient and productive as well as to enhance YOUR access to quality health care. If YOU choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for YOU. YOUR decision will have no adverse effect on YOUR care from the CLINIC or on YOUR relationship with our employees.

YOUR signature below also indicates YOUR authorization of the above mentioned activities.

■ It is the policy of this CLINIC to send you marketing information - including health news letters.

As required by the Privacy Regulations, I hereby acknowledge that this is the most current copy of the CLINIC's "NOTICE OF PRIVACY AGREEMENT" with the current revision

date of: ______________________________.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide CLINIC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Authorized Facility Signature Date

☐ I have read the Privacy Notice and understand my rights contained in the notice. However I do not agree to the above notice. Therefore I will not sign above. My signature below this line indicates that I do not agree to this notice, however I have received a copy of this NOTICE as required by law.

____
Patient's Name (print)

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Authorized Facility Signature Date