TRUE NORTH CHIROPRACTIC • DR. JAKE WILLIAMS, B.Sc., D.C.

HIPAA (Health Insurance Portability Accountability Act)

Notice of Privacy Practices: Appointment Calls, Open Room Adjusting & Healthcare Information

Our HIPAA Notice of Privacy Practices describes the privacy practices of True North Chiropractic. We respect our legal obligation to keep health information private and, by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our notice that are currently in effect, and if you request, 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 (#164.524).

APPOINTMENT - CALLS, TEXTS & EMAIL

True North Chiropractic may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. In an effort to communicate in a more efficient and timely manner, True North Chiropractic may use email and text communications to communicate with you. These communications will include, but not limited to: appointment confirmations, scheduling, general questions and communications with mutual healthcare providers. If contact is made by phone and you are not home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

- Authorized Email Address: _____

- Authorized Text Number: _____

OPEN ROOM ADJUSTING

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally, comments about you or other patient's symptoms, improvement or lack thereof may be discussed during and at your office visit.

HEALTHCARE INFORMATION

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decided to contest any of your claims.

Information that we use or disclose, based on the authorization you are giving us, may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.
You have the right to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the other methods we use to obtain reimbursement for your care.

Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

( ) Spouse: _____ ( )Yes, Health Info ( )Yes, Billing Info ( )Yes, Scheduling

( ) Parent/s or Guardian/s: _____ ( )Yes, Health Info ( )Yes, Billing Info ( )Yes, Scheduling

( ) Relative/Friend/Other:_____ ( )Yes, Health Info ( )Yes, Billing Info ( )Yes, Scheduling

This notice is effective as of _____, 20_____. This authorization will expire seven years after the date in which you last received services from us.

Acknowledgment of Receipt of this Notice

As a patient of True North Chiropractic, I acknowledge that I have received and seen this notice and understand that I may receive a copy of this form when needed. I understand that True North Chiropractic respects their legal obligation to keep health information private unless required by law. By signing below, I indicate that I agree to these conditions and I understand I authorize disclosure of my health information in the manner described above.

_____
Patient Name *(Printed)*

_____ _____
Patient Signature (or Legal Guardian) Date