

## **NOTICE OF PRIVACY PRACTICES**

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

### **Uses and Disclosures**

Here are some examples of how we might have to use or disclose your health care information:

- 1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
- 4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

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.

### **Permitted uses and disclosures without your consent or authorization**

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- 1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
- 2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
- 3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
- 4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
- 5) We are permitted to use or disclose your health information in response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.

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- 6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
- 7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- 8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
- 9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 10) We are permitted to use or disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Tennessee's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

### **Your right to revoke your authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

- 1) If we have already released your health information before we receive your request to revoke your authorization.
- 2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

### **Your right to limit uses or disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

### **Your right to receive confidential communication regarding your health information**

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

### **Your right to inspect and copy your health information**

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time

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frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

### **Your right to amend your health information**

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

### **Your right to receive an accounting of the disclosures we have made of your records**

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

1. those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. those disclosures made to you.
3. those disclosures we are permitted to make without your consent or authorization as described above.
4. those disclosures made based on an authorization you signed.
5. those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. those disclosures for national security or intelligence purposes.
7. those disclosures made to correctional officers or law enforcement officers.
8. those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

### **Your right to obtain a paper copy of this notice**

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

### **Our duties**

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

### **Re-disclosure**

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**Re-disclosure**

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

**Your right to complain**

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

**To contact us**

If you would like further information about our privacy policies and practices please contact:

Dr. Kevin Bradshaw  
4331 Old Hickory Blvd. Suite C  
Old Hickory, TN 37138  
615-847-2770

This notice is effective as of 9-5-14. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.



## Informed Consent

Chiropractic care like other methods of health care delivery is associated with potential risks factors. Although chiropractic care is very safe, the patient needs to be informed about all potential risks related to treatment protocol before consenting to treatment. Known risks associated with chiropractic treatment include the following:

**Soreness** - Sometimes soreness is a normal response to chiropractic adjustments. If you are sore following an adjustment, please advise your doctor.

**Connective Tissue Injury** – In rare instances, chiropractic treatment has been known to exacerbate a disk injury or cause other minor joint, ligament, tendon or other connective tissue injury. Please advise your doctor if you have a history of any of the previously mentioned conditions.

**Physical Therapy Burns** – Some physical therapy may possibly cause slight burns to the skin. This effect is rare, but if you experience any irritation to the skin, please report it to the doctor immediately.

**Rib Injury** – Dorsal Spine Adjustments have been known in rare instances to cause rib injury and/or fracture. Bradshaw Chiropractic utilizes X-ray to minimize this risk.

**Stroke** – It is estimated that 1 out of every 3 million cervical spine adjustments results in stroke. Dr. Bradshaw does a thorough examination to rule out any risks associated with this occurrence.

**Other Risks** – Occasionally other side effects may occur with chiropractic treatment. Please inform your doctor immediately if you are experiencing any complications associated with treatment protocol.

If you have any questions regarding this form or risks associated with chiropractic care, please address them with your doctor. Our goal is to provide you with the very best care. If you are not completely satisfied, please let your doctor or office staff know and we will attempt to earn your satisfaction.

I, the undersigned, hereby authorize the staff at Dr. Bradshaw's office to administer such examinations and treatment as they deem necessary. Having read this form in its entirety, I give my informed consent for chiropractic treatment.

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Patient Signature

Date

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Parent/Legal Guardian Signature

Date