PATIENT PRIVACY POLICY AND PRACTICE

Patient privacy is an integral part of ethical service. In our effort to meet your health care needs it is imperative that we collect information about you.

In order to provide you with appointment reminders, information about treatment alternative and/or other health-related information, your physician and/or staff member may need to use your name, address, and/or telephone number. (If you not home when we call to verify your appointment, we will leave a reminder message for you on your answering machine).

All medical records are confidential and are cared for with a high degree of security. Prior to any information being released, you, the patient, are required to sign a medical release form.

Sometimes it is necessary to refer you to another health care provider or hospital for treatment. If this happens it may be necessary for your physician or a staff member to disclose your health information (including all of your clinical records) to the person/establishment you are referred to.

At other times our insurance and billing staff may have to disclose your examination records and/or billing records to a third party. (Some examples of this might be information needed by an insurance company, an HMO, a PPO or your employer- if they are potentially responsible for payment for services rendered). Receipt of a subpoena or a legal representative's request for information is also honored.

A Chiropractic Tradition's physicians and staff will always respect and protect your right to privacy.

A Chiropractic Tradition

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of A Chiropractic Tradition's (the "Practice") Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as the term is defined under the Health Insurance Portability and accountability Act of 1966 "HIPPA") that may be made by the practice, and of my rights and the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I so choose.

_____ _____

Patient Name Date

_____ _____

Patient's Signature Signature of Guardian if Patient under 18 Years Old

IF PATIENT REFUSES TO SIGN ACKNOWLEDGEMENT, COMPLETE THIS SECTION:

____ Patient refuses to sign acknowledgement.

_____ (A Chiropractic Tradition's EMPLOYEE/POSTION) made the following efforts to attempt to obtain a signature from the patient:_____