COLUMBIA COUNTY CHIROPRACTIC CENTER, LLC
279 SW MAIN BLVD. LAKE CITY, FL 32025-7050
(386)752-4313

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

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.

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 payors, 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) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

- (b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

- (c) Personal Representative -To a person 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.

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. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

SIGN-IN LOG

The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is 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. 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

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 and to request a revocation, you must submit a written request to the Practice's COMPLIANCE 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 COMPLIANCE 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.

· (c) Receive confidential communications or PHI by alternative means or at alternative locations; you must make your request in writing to the Practice's COMPLIANCE OFFICER. The Practice will accommodate all reasonable requests.

· (d) Inspect and obtain a copy your PHI as provided by law. To inspect and copy your PHI, you are requested to submit a written request to the Practice's COMPLIANCE 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 law. To request an amendment, you must submit a written request to the Practice's COMPLIANCE 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 law. 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 COMPLIANCE OFFICER.

· (h) 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 COMPLIANCE OFFICER. All complaints must be in writing.

· (i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's COMPLIANCE OFFICER, Marty Fraser, at 752-4313 or via e-mail at drmathis@columbiachiro.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 and Section 456.057 relating to patient records ownership, control and disclosure.

· (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 all of your 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.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below who is the COMPLIANCE OFFICER and Contact person appointed for this practice. The COMPLIANCE OFFICER is Marty Fraser.

You may file a complaint with the COMPLIANCE OFFICER if you believe that your privacy rights have been violated relating to release of your protected health information. The complaint process:

1. Send a written letter to the Practice contact named above, including the following information:
   a. Name and Address.
   b. Social Security Number or Patient Identification Number.
   c. Detailed description of the circumstances surrounding your complaint.
   d. Contact information.
   e. Signature and Date.

2. Please allow fourteen (14) business days for an answer from our practice regarding your complaint.

3. If you are not satisfied with our response to your complaint, you may notify the Secretary of the Department of Health and Human Services at the Office of Civil Rights, Medical Privacy, Complaint Division, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, HHH Building, Room 509H, Washington, DC 20201. Phone toll-free: 1-888-627-7748; TTY: 1-886-788-49898; Email through the Internet: www.hhs.gov/ocr. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/14/2003.

COLUMBIA COUNTY CHIROPRACTIC CENTER, LLC

DARREL T. MATHIS, D.C., F.A.C.O.
JAMES R. FRASER, III, D.C.

279 SW MAIN BOULEVARD
LAKE CITY, FL 32025-7050

OFFICE; 386.752.4313
FAX: 386.752.8356
WWW.COLUMBIACHIRO.COM

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I am provided the opportunity to review a copy of the Notice of Privacy Practices, found on our website, www.columbiachiro.com, and that I have read it or declined the opportunity to read it, but do understand that Columbia County Chiropractic is bound by the Notice of Privacy Practices regarding my medical records.

I understand that this form will be placed in my patient chart and maintained for six years.

Date______________________

Patient name_______________________________________
(please print)

Patient signature_____________________________________

Parent/Guardian_____________________________________
(if patient is a minor)

* * * If you would like a copy of the Notice of Privacy Practices for your own records,* * *
please let us know at the front desk and we will provide one for you.

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RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize **COLUMBIA COUNTY CHIROPRACTIC** to release a copy of my patient records or x-rays containing protected health information to ______________________

____. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

____ ___________________
Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

____________________________________ Date Signed

Specific description of information to be disclosed: _________________________________

____

____

____

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PATIENT'S REQUEST FOR COPIES OF RECORDS

I hereby request a copy of my patient records and x-rays from **COLUMBIA COUNTY CHIROPRACTIC**. I understand that Section 460.413(m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I further understand that Section 456.057(4), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

__________________________________ ____________________
Patient's or Patient's Legal Representative's Signature Date Signed

YOU MAY REFUSE TO SIGN THIS REQUEST.

DESCRIPTION OF DOCUMENTS FURNISHED TO PATIENT: ____________________

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____

____

DESCRIPTION OF X-RAYS FURNISHED TO PATIENT: __________________________

____

____

DATE RECORDS OR X-RAYS FURNISHED TO PATIENT: ________________________

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REQUEST TO INSPECT AND COPY MEDICAL RECORDS

Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify what records you would like to inspect:

□ All Records
□All records between the dates of ___________ and _____________.
□ Records pertaining to
____

Please specify what records you would like to copy:

□All records
□All records between the dates of ___________ and _____________.
□Records pertaining to
____

Please specify method of release:

_ Pick-up
_ Certified Mail to:

*** Please note: A reasonable fee will be charged for the cost of copying records and mailing.**

Name:	**Title/Business:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Relationship to Patient:**

Patient/Guardian Signature: ______________________________ Date: ______________

Internal use only:

Completed By: ____

Date Records Mailed/Picked-up: _______________________________________
Fees for Copying and Mail: _______________________________________

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REQUEST TO AMEND MEDICAL RECORDS

If you believe there is information in your medical record that may be inaccurate or incomplete, you have the right to request an amendment or clarification of information in your record.

Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify the exact amendment you would like to make to your medical record:

____

____

____

____

Please describe your reasoning for the above requested amendment:

____

____

____

**If additional space is required, please attach a separate, typed or neatly written statement to this request form.*

Patient/Guardian Signature: _______________________________ Date: ____________________

Notary Public:

____

Internal use only:

Request:

☐Granted

☐Denied

☐ Information was created by a Third Party

☐Information is not part of the medical information kept by this practice

☐ Information provided by the requesting party is inaccurate or incomplete

☐Information in the record is accurate

Completed By: ________________________ Date of Completed Amendment: ______________

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REQUEST TO RESTRICT USES AND DISCLOSURES

You have the right to request restrictions on how this practice makes certain uses and disclosures of your personal health information for treatment, payment and healthcare operations. Please note that this practice is not required to grant your request, but we will do our best to accommodate your wishes. If this request is approved, it shall not apply if the information for which you request to limit is required to provide emergency treatment to you.

Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please describe in detail the type of information you would like to limit:

____

____

____

Please specify whether you would like to limit the following:

- □ Practice Use of the above specified information
- □ Practice Disclosure of the above specified information
- □ Both the Use and Disclosure of the above specified information

To whom would you like these limits to apply?

- □ Parent(s)
- □ Spouse
- □ Children
- □ Guardian
- □ Other

Describe:
____

Patient/Guardian Signature: _______________________________Date: ___________________

Internal use only:
Request:

□ Granted □ Denied

Reason for Denial:

____

____

Completed By: _____________________________ Date: _____________________________

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REQUEST FOR AN ACCOUNTING OF USES AND DISCLOSURES

You have the right to request an accounting of uses and disclosures of your personal health information. This accounting does not include uses and disclosures related to treatment, payment, healthcare operations, disclosures for which you may have already provided written authorization, national security intelligence or uses and disclosures made to correctional institutes or law enforcement officials. One accounting per year shall be provided at no charge. Additional requests for accountings in the same calendar year shall be subject to additional fees.

Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify the dates for which you would like an accounting: ***Please note: All requests must be for disclosures after April 14, 2003, and cannot be for a period of more than six (6) years prior to the date of your request for an accounting.***

□ Accounting between the dates of _________________ and ____________________.

Format of your accounting:

□ Paper □ Electronic

Please specify method of release:

□ Pick-up □ Certified Mail to:

*** Please note: A reasonable fee will be charged for the cost mailing**

Name:	**Title/Business:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Relationship to Patient:**

Patient/Guardian Signature: ________________________________ Date: _________________

Internal use only:

Completed By: ____ Date: ___________________

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ACCOUNTING OF DISCLOSURES FORM

There is recorded, on this form, any and all disclosures of information contained in the medical record to any third party, including the purpose of the disclosure, required to be maintained by Florida Statute 456.057 (10) and provided to a patient upon request pursuant to HIPAA regulations. This form shall be maintained as part of the patients' records pursuant to Florida Statute 456.057 (10). A copy of this form shall be provided to any patient requesting an accounting or a copy of their patient records. This form will be maintained as part of the medical records for at least six years.

_________________________________ _________________

Signature of COMPLIANCE OFFICER Date Provided to Patient

DATE Of Disclosure	PERSON/ENTITY To Whom Disclosures Were Made	INFORMATION DISCLOSED	REASON for Disclosure

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ELECTRONIC TRANSFER OF PROTECTED HEALTH INFROMATION PRIVACY PRACTICE

COLUMBIA COUNTY CHIROPRACTIC seeks to protect the privacy of Protected Health Information stored on computers of **COLUMBIA COUNTY CHIROPRACTIC** or transmitted via the internet.

Only authorized employees shall have access to computers on which Protected Health Information is stored. All computers will be protected with a password for use by authorized employees. 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 discs onto which Protected Health Information has been copied. The owner will take appropriate steps to protect the information on the discs from unauthorized disclosure. Back up discs will be stored in a secure place.

Any electronic claims that may be filed after October 16, 2003, using the software that is approved for electronic transmissions of Protected Health Information and which protects the privacy of such information.

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.

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REQUEST FOR SPECIAL CONFIDENTIAL COMMUNICATIONS PROCEDURES

I hereby request to **COLUMBIA COUNTY CHIROPRACTIC** that all written communications to be mailed only to the following address:

____
____
____

I hereby request to **COLUMBIA COUNTY CHIROPRACTIC** that all telephone calls placed to me only be placed to: ______________________________.

I hereby request to **COLUMBIA COUNTY CHIROPRACTIC** that no voice mail messages be left on the above listed or any other telephone listings relating to me.

__________________________________ _________________________
Patient's Signature Patient's Date of Birth

+ +

For Use by COMPLIANCE OFFICER Only

Practice: ____ Accepts _____ Denies

Signature of Compliance Officer:____

Date: ____________________________________

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PATIENT COMPLAINT FORM

Patient Name: _________________________________

Date of Birth: ___________________

Name of person submitting complaint if other than the patient: ___________________________

Relationship to patient: _____________________________

Date of Occurrence: ______________________________

Name of Practice employee involved in matter: __________________________________

Description of occurrence and reason for complaint:

____

____

Describe the action you want this office to take relating to this occurrence:

____

____

____ ____________________________
Signature Date

+ +
For use by the COMPLIANCE OFFICER

Description of action taken to address complaint:

____

____

Signature of COMPLIANCE OFFICER:____

Date: __________________________