

## 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.

### **OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU**

Federal law requires that we provide you with this detailed written notice of our privacy policies. In this notice, we describe how we may use and disclose your health information. We are required by law to protect the privacy of health information that identifies, or can be used to identify, a patient. This information is called protected health information, or PHI. This notice describes your rights as our patient, and our obligations regarding the use and disclosure of your PHI.

We are required by law to:

- Maintain the privacy of your PHI
- Give you this notice of our legal duties and privacy policies with respect to PHI
- Comply with the terms of this notice of privacy policies

We reserve the right to make changes to this notice and to make such changes effective for all PHI we may already have about you. If and when this notice is changed, we will post a copy in our office in a prominent location.

### **HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU**

**Treatment:** We may use and disclose your PHI to provide, coordinate or manage your health care; when you need a lab test, x-ray, or other health care service; or when referring you to another health care provider for treatment.

**Payment:** We may use and disclose your PHI to another party, such as an insurance carrier, an HMO, PPO, or your employer, if they are potentially responsible for the payment of your services.

**Health Care Operations:** We may use and disclose your PHI for quality control purposes or for other administrative purposes to efficiently and effectively run our practice. We may use and disclose your PHI 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.

### **OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR CONSENT OR AUTHORIZATION**

- If we are required to do so by federal, state, or local law.
- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you as an inmate.
- If we provide care services to you in an emergency.
- If we are required by law to treat you and we are unable to obtain your consent after attempting to.
- If there are barriers to communicate with you, but in our professional judgment we believe that you intend for us to provide care.

All other uses and disclosures of your PHI will only be made with your written authorization. You may revoke your authorization to us at any time, in writing, except for:

- If we have already released your health information before we receive your request to revoke your authorization.
- 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 the decide to contest any of your claims.

**Right to request restrictions:** You have the right to request additional restrictions on your PHI that we may use for treatment, payment, and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that are otherwise permitted by the privacy rule. We are not required to agree to your restrictions. If we agree with your restrictions, the restriction is binding on us.

**Right to receive confidential communication:** You have the right to request that you receive communications regarding your PHI in a certain manner or certain location. Please make this and all requests in writing.

**Right to inspect and copy:** You have the right to inspect and/or copy your PHI in certain records that we maintain.

**Right to amend:** You have the right to request that we amend your PHI, as long as such information remains in our files.

**Right to receive an accounting of disclosures:** You have the right to request an accounting of certain disclosures we have made of your PHI. It excludes disclosures required for your treatment, to obtain payment for your services, or to run our practice; disclosures made to you or to individuals involved with your care; disclosures for national security of intelligence purposes; disclosures made to correctional officers or law enforcement officers; and 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 in the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to cancel your request.

**Right to complain or to contact us:** If you feel that your privacy rights have been violated, you may file a complaint with us, or with the Secretary of the United States Department of Health and Human Services. We will not take any action against you if you file a complaint. To file a complaint with our office, or to contact us, please use the following address:

Dr. Michael J. Cunha • 28 Market Street • Swansea, MA 02777 • (508) 379-1191

This notice was published and first became effective on April 14, 2003

**PRIVACY NOTICE ACKNOWLEDGEMENT**

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. Michael J. Cunha's Notice of Privacy Practices.

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

\_\_\_\_\_  
Date

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

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