**HIPAA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact Dr. Aaron M Hoffmann, Privacy Officer.

This Notice of Privacy Practices describes how we

may use and disclose your protected health

information to carry out treatment, payment or health

care operations and for other purposes that are

permitted or required by law. It also describes your

rights to access and control your protected health

information. “Protected health information” is

information about you, including demographic

information, that may identify you and that relates to

your past, present or future physical or mental health

or condition and related health care services.

We are required to abide by the terms of this Notice of

Privacy Practices. We may change the terms of our

notice, at any time. The new notice will be effective

for all protected health information (PHI) that we

maintain at that time. Upon your request, we will

provide you with any revised Notice of Privacy

Practices by calling the office and requesting that a

revised copy be sent to you in the mail or asking for

one at the time of your next appointment.

**1. Uses and Disclosures of PHI**

You will be asked to sign a consent form. Once you

have consented to use and disclosure of your PHI for

treatment, payment and health care operations by

signing the consent form, your physician will use or

disclose your PHI as described in this Section. Your

PHI may be used and disclosed by your physician, our

office and others outside of our office that are involved

in your care and treatment for the purpose of providing

health care services to you. Your PHI may also be

used and disclosed to pay your health care bills and to

support the operation of the physician’s practice.

Following are examples of the types of uses and

disclosures of your PHI that this office is permitted to

make once you have signed our consent form. These

examples are not meant to exhaustive, but to describe

the types of uses and disclosures that may be made

by our office once you have provided consent.

**TREATMENT:**

We will use and disclose your PHI to provide,

coordinate or manage your health care and any

related services. This includes the coordination or

management of your health care with a third party that

has already obtained your permission to have access

to your PHI. We may, for example, disclose your PHI

to another health care provider who, at the request of

your physician, becomes involved in your care by

providing assistance with your health care diagnosis

or treatment to your physician.

**PAYMENT:**

Your PHI will be used, as needed, to obtain payment

for your health care services. This may include

certain activities that your health insurance plan may

undertake before it approves or pays for health care

services we recommend for you such as: making a

determination of eligibility or coverage of insurance

benefits, reviewing services provided to you for

medical necessity, and undertaking utilization review

activities. If you pay for all or part of services using a

check or credit card, information that may identify you,

such as your name and address, may be disclosed to

the credit card company and/or bank.

**HEALTHCARE OPERATIONS:**

We may use or disclose, as-needed, your PHI in order

to support the business activities of this office/practice.

These activities include, but are not limited to, quality

assessment activities, employee review activities,

training of chiropractic students, licensing, marketing

and fundraising activities, and conducting or arranging

for other business activities.

**For example, we may disclose your PHI:**

To chiropractic interns/students

To contact you via phone, electronic mail,

fax, or regular mail fo**r appointment**

**reminders**, insurance issues, health care

issues etc.

To leave you a message at the number(s)

you provide to use

To maintain a **sign-in sheet** to verify your

visit

To **call you by name in the waiting room**

To maintain a “Thank you for referral” board

To provide you with information about

treatment alternatives or other health-related

benefits and services that may be of interest

to you

To send you birthday, holiday or reminder

Cards

**HEALTHCARE OPERATIONS: (con’t)**

To send and receive patient surveys

To send you information about products or

services that we believe may be beneficial

to you

To contact you for fundraising activities

supported by our office

**We will share your PHI with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice**.

Whenever an arrangement between our office and a

business associate involves the use or disclosure of

your PHI, we will have a written contract that contains

terms that will protect the privacy of your PHI.

**Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law.** You may revoke this authorization, at any time, in writing, except to the extent that your physician or this practice

has taken an action in reliance on the use or

disclosure indicated in the authorization.

We may use and disclose your PHI in the following

instances. You have the opportunity to agree or

object to the use or disclosure of all or part of your

PHI. If you are not present or able to agree or object

to the use or disclosure of the PHI, they your

physician may, using professional judgment,

determine whether the disclosure is in your best

interest. In this case, only the PHI that is relevant to

your health care will be disclosed.

**Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person’s involvement in your health**

**care.** If your are unable to agree or object to such a

disclosure, we may disclose such information as

necessary if we determine that is in your best interest

based on our professional judgment. We may use or

disclose your PHI to an authorized public or private

entity to assist in disaster relief efforts and to

coordinate uses and disclosures to family or other

individuals involved in your health care.

**We may use or disclose your PHI in an emergency treatment situation**. If this happens, your physician and/or this office shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

We may use and disclose PHI if your physician and/or

our office attempts to obtain consent from you but is

unable to do so due to substantial communication

barriers and the physician determines, using

professional judgment, that you intend to consent to

use or disclosure under the circumstances.

**We may use or disclose your PHI without your consent or authorization:**

As required by law

For public health issues/activities

For communicable disease issues/activities

For health oversight activities (audits,

investigations, inspections, etc.)

To report suspected or blatant

abuse/neglect

To report issues as needed/required to the

FDA

In response to legal proceedings (to the

extent that such disclosure is expressly

authorized)

For law enforcement purposes (so long as

applicable legal requirements are met)

To comply with workers’ compensation laws

**This list is NOT exhaustive**, for more details you may request a more complete list in writing. Please contact the Privacy Officer.

Under the law, we must make disclosures to you and

when required by the Secretary of the Department of

Health and Human Services to investigate or

determine our compliance with the requirements of

Section 164.500 et.seq.

**2. YOUR RIGHTS**

The following is a statement of your rights with

respect to your protected health information and

a brief description of how you may exercise these

rights.

**You may inspect and obtain a copy**

**of your PHI that is contained in your**

**clinical record at this office for as**

**long as we maintain the PHI.** (Under

federal law, there is some information

that you may not inspect or copy). You

must make the request in writing to our

Privacy Officer. Your request must

include the date it was made and the

reason for the request and the specific

restrictions you are requesting. Please

contact our Privacy Officer if you have

questions about access to your clinical

record.

**This office reserves the right to deny**

**your request.** We will avail you of that decision in writing.

**You have the right to request that**

**this office not use or disclose any**

**part of your PHI for treatment,**

**payment, or healthcare operation.**

**YOUR RIGHTS (con’t)**

You may also request that any part of

your PHI not be disclosed to family

members or friends who may be

involved in your care or for notification

purposes as described in this Notice of

Privacy Practices. Your request must

be in writing and must state the specific

restriction requested and to whom you

want the restriction to apply.

**Your physician is NOT required to**

**agree to a restriction that you may**

**request**.

**You have the right to request to**

**receive confidential**

**communications from us by**

**alternative means or at an**

**alternative location**. We will

accommodate reasonable requests.

We may also condition this

accommodation by asking you for

information as to how payment will be

handled or specification of an

alternative address or other method of

contact. Please make this request in

writing to our Privacy Officer.

**You may request an amendment of**

**PHI about you as long as we**

**maintain this information**. In certain

cases, we may deny your request for

an amendment. If we deny your

request for amendment, you have the

right to file a statement of

disagreement with us and we may

prepare a rebuttal. Please contact our

Privacy Officer to if you have questions

about amending your clinical record.

**You may request to receive an**

**accounting of certain disclosures**

**we have made, if any, of your PHI.**

This does not apply to disclosures for

purposes other than treatment,

payment or healthcare operations as

described in this document. It excludes

disclosures made to you, to family

members or friends involved in your

care, or for notification purposes. You

have the right to receive specific

information regarding these disclosures

that occurred after April 14, 2003. The

right to receive this information is

subject to certain exceptions,

restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us, upon request.**

**3. COMPLAINTS**

You may complain to us or to the Secretary of Health

and Human Services if you believe your privacy rights

have been violated.

**You may file a complaint with us by writing to:**

Privacy Officer

Hoffmann Chiropractic Inc.

310 Maple Ave L 04

Barrington RI 02806

**If you must file a complaint with the Secretary of the U.S. Department of Health and Human**

**Services** it must be in writing; contain the name of the entity against whom you are making the complaint;

describe the nature of the complaint; and it must be

filed within 180 days of the time you should have

become aware of the problem.

We will not retaliate against you for filing a complaint.

**We reserve the right to change our privacy notice and the terms of this Notice at any time,** provided that applicable law permits such changes. These changes and new terms will be effective for all PHI that we maintain, create or receive prior to changes.

**4. TREATMENT ENVIROMENT**

This office utilizes an **“open door adjusting”**

environment for ongoing patient care. “Open door

adjusting” involves having the **treatment room door open during your office visit**. Patients are within earshot of other patients and staff. This environment is used for ongoing care and is **NOT** the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to

quality health care and health information. If you

choose not to be adjusted in an open-adjusting

environment, other arrangements will be made for

you.

This notice was published and becomes effective on

**April 14, 2003.**

**March 14, 2012 updated**