



NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND PHYSICAL THERAPY 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 our 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. 164.520 (b)(1)(iii) (A). 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.

OUR PRIVACY PLEDGE

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

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 if we are providing health care services to you based on the orders of another health care provider.
- 2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
- 3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- 5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five 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. 164.508(b)(5)(i)

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. If you wish to revoke your authorization please write to us at:

Office Manager
Schubbe Resch Chiropractic and PT Center
2200 S Kensington Drive
Appleton WI 54915

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 RECIEVE 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.

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 RECIEVE 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:

- * those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- * those disclosures made to you.
- * those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- * those disclosures for national security or intelligence purposes.
- * those disclosures made to correctional officers or law enforcement officers.
- * 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

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 for 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 addressed to:

Schubbe Resch Chiropractic and PT Center
2200 S Kensington Drive
Appleton WI 54915

or

Department of Health and Human Services
233 N Michigan Ave Suite 240
Chicago Ill 60601

TO CONTACT US

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

Office Manager
2200 S Kensington Drive
Appleton WI 54915
Phone 920-738-0200

I hereby authorize Schubbe Resch Chiropractic & PT Center to contact me by mail or leave telephone messages regarding account information, appointments, and or personal medical information and /or services.

This notice is effective as of . 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.

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Limitation on Liability

AS PARTIAL CONSIDERATION FOR YOUR USE OF AND ACCESS TO THIS WEB SITE, YOU AGREE THAT: (I) IN NO EVENT WILL SCHUBBE RESCH

CHIROPRACTIC & PHYSICAL THERAPY CENTERS, LLC OR ANY OTHER PARTY INVOLVED IN CREATING, PRODUCING, OR DELIVERING THIS WEB SITE OR ANY SITE LINKED TO THIS WEB SITE, BE LIABLE TO YOU IN ANY MANNER WHATSOEVER FOR ANY DECISION MADE OR ACTION OR NON-ACTION TAKEN BY YOU IN RELIANCE UPON THE INFORMATION PROVIDED THROUGH THIS WEB SITE; AND (II) THE AGGREGATE LIABILITY OF SCHUBBE RESCH CHIROPRACTIC & PHYSICAL THERAPY CENTERS, LLC, OR ANY OF HIS DISTRIBUTORS OR DEALERS, ARISING FROM OR RELATING TO THIS AGREEMENT (REGARDLESS OF THE FORM OF ACTION OR CLAIM, E.G. CONTRACT, WARRANTY, TORT, STRICT LIABILITY, NEGLIGENCE, MALPRACTICE, FRAUD, AND/OR OTHERWISE) IS LIMITED TO THE PURCHASE PRICE OF ANY PRODUCTS YOU PURCHASED FROM SCHUBBE RESCH CHIROPRACTIC & PHYSICAL THERAPY CENTERS, LLC IN THE RELEVANT TRANSACTION; AND (III) SCHUBBE RESCH CHIROPRACTIC & PHYSICAL THERAPY CENTERS, LLC SHALL NOT IN ANY CASE BE LIABLE FOR ANY DIRECT, INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR PUNITIVE DAMAGES, EVEN IF SCHUBBE RESCH CHIROPRACTIC & PHYSICAL THERAPY CENTERS, LLC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

If any provision of this Agreement is held to be illegal or unenforceable, then such section shall be eliminated or limited to the minimum extent necessary and the remainder (including any revised portion of the agreement) shall remain and have full force and effect.