



NOTICE OF PRIVACY PRACTICES

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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.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received 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 the right to your health information if they decide to contest any of your claims.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information. You have the right to refuse to give this authorization. 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.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical treatment.
- The right to see and copy your protected health information
- The right to receive confidential communications about your medical condition and treatment
- The right to amend or make corrections to your personal health information
- The right to receive an accounting disclosure of your personal health information.
- The right to receive a paper copy of our privacy notice



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REQUESTS TO INSPECT PERSONAL AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and/or copy your health information for seven years from the date the record was created. We require your request to inspect and/or copy your health information be in writing.

YOUR RIGHT TO COMPLAIN

You may complain to us 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:

Jeffrey R. Dexter, DC | Marietta Health & Wellness Center | 325 Fourth Street | Marietta, OH 45750

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 to all of your health information.

TO CONTACT US

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

Jeffrey R. Dexter, DC | Marietta Health & Wellness Center | 325 Fourth Street | Marietta, OH 45750 | 740-376-9944

TO THE PATIENT

This notice is in effect as of March 13, 2007. 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 (please print)

Patient signature

Date

Signature of parent or legal guardian