

West Maple Chiropractic & Wellness LLC

17007 Evans Plaza
Omaha, NE 68116
(402) 934-4650

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI)

This notice describes how health 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, please call (402) 934-4650.

Our Privacy Pledge

We want you to understand that we respect your privacy. Other than the necessary uses and disclosures we described above, we will not sell your health information or provide any of your health information to any outside marketing company.

Our practice is dedicated to, and we are required by applicable federal and state laws to maintain privacy of your health information. These laws also require us to provide you with this Notice of our Privacy Practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of February 11, 2013 and will remain in effect until we replace it.

Changes to Notice:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you upon request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed below. The most up-to-date Notice is also available online at www.westmaplechiro.com.

Permitted Uses and Disclosures of Health Information:

1. **TREATMENT, PAYMENT, HEALTH CARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and healthcare operations. Examples of these activities are as follows:
 - Treatment: We may use or disclose your health information to other health care providers providing treatment to you.
 - Payment: We may use and disclose your health information to obtain payment for services we provide to you.
 - Health care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include clinical education, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance and other business operations.
2. **AUTHORIZATIONS:** You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice. The following uses and disclosures will be made only with authorization from the individual in writing: uses and disclosures for marketing purposes and uses or disclosures that constitute the sale of PHI.
3. **RESTRICT DISCLOSURES TO HEALTH PLANS:** You also have the right to restrict disclosures of PHI to health plans if you have paid for services completely out of pocket.
4. **DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.

5. **MARKETING:** We will not use your health information for marketing communications without your written authorization.
6. **FUNDRAISING:** You may receive information about fundraising materials but you may opt out of further fundraising communications.
7. **USES OR DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.
8. **PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
9. **LAW ENFORCEMENT/NATIONAL SECURITY:** Under certain circumstances, we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances, we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence and other national security activities.
10. **APPOINTMENT REMINDERS/BIRTHDAYS CARDS/EMAILS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, emails, postcards or letters).
11. **BREACH NOTIFICATION:** We as the provider must notify an affected individual of a breach of unsecured PHI and it must be within 30 days of that breach.

Patient Rights:

1. **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. If you request copies, we will charge you our standard copying fee for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.
2. **ACCOUNTING OF CERTAIN DISCLOSURES:** Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before February 11, 2013. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
3. **RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and health care operations purposes. Depending on the circumstances of your request we may or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.
4. **AMENDMENTS TO RECORDS:** You have the right to request that we amend your health information. Such requests must be made in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

5. ELECTRONIC NOTICES: If you receive this Notice on our website (www.westmaplechiro.com) or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure or access to your health information you may complain to us using the contact information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Chief Privacy Officer

Dr. Scott Moon c/o West Maple Chiropractic & Wellness, LLC.
17007 Evans Plaza
Omaha, NE 68007
(402) 934-4650

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information, and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

I would like to receive a printed copy of the Notice of Privacy Practices (HIPAA Privacy Policy).

*I acknowledge that I do **not** wish to obtain a copy of the Notice of Privacy Practices (HIPAA Privacy Policy) at this time. I understand I can request a copy of this Notice from the front desk at any time in the future. I also understand this Notice is available online at www.westmaplechiro.com.*

Patient's Name (Print)

Patient's Signature

Date

Acknowledgement of Receipt For A Minor or Person Represented by Another Party

Patient's Name (Print)

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date