INCLEDON CHIROPRACTIC
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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.

In the course of your care as a patient, we may use or disclose personal and health information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, PPO or your employer (if they or may be responsible for the payment of your services). Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care proviced to you or the reimbursement avenues associated with your care. Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*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 in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you but in our professional judgment, we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing. We are required by State and Federal Law to maintain the privacy of your patient file and the protected health information therein and provide you with this notice of our privacy practices with respect to your health information and the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made t o our privacy notice, we will notify you in writing as soon as possible following the changes. Any change made in our notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the Federal Privacy Rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities or you would like further information about our privacy practices or policies, please contact Dr. James Incledon, D.C.

This office is also in the practice of sending postcards for reasons including recalls, appointment reminders, etc. but is not limited to these events. It is also the practice of this office to have patients sign in for visits. Your name is made visible to other practice members when you sign in. If you choose not to have postcards sent to you or have your name appear on our sign-in sheet, we will gladly make other arrangements for these office procedures. The use of these office procedures is 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.

This notice is effective as of 4/14/2003. This notice and any alternations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____
Name (Printed Please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____
Name of Personal Representative Printed Personal Representative Signature Date

Description of authority to act on behalf of the patient: Parent Guardian Other