

DR. PAUL GRAVES CHIROPRACTIC

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.

Our Legal Duty

We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protect health information. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

You may request a copy of our notes at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at Dr. Paul Graves Chiropractic, Inc. 7500 Stonebrook Pkwy Suite 103, Frisco, Texas 75034. Telephone: 972-377-7117.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third party for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, CMS, or other governmental or third party payers, or any of the above entities to perform such functions.

Copies of your medical information may be delivered to a primary care physician who is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you or leave a message to provide appointment reminders, birthday cards, holiday related cards, and promotional information. I give permission to treat me in an open room where other patients are also being treated. I am aware that other people in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I will notify the doctor and or staff for a private room.

We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues.

Individual Rights

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We charge a cost-based fee for copying of records and for postage.

Questions and Complaints

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

Patient Signature _____ Date _____
Parent/Guardian _____

Patient Number: _____