2619 W 11th Street Rd, Ste 13
Greeley, CO 80634
(970) 637-8486

HIPPA PRIVACY POLICY NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Homeplace Chiropractic, LLC (the Practice) is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. If you have further questions, please contact Jolene Laughlin, D.C.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information: Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate: To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative: To a person who, under applicable law, has the authority to represent you in making decisions related to your health care

(d) Emergency Situations:

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers: If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities: Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence: To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities: Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceedings: For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes: In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner: The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation: If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research: If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

This notice was revised, published, and became effective on June 22, 2023.

(n) Avert a Threat to Health or Safety: The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation: If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

VI. YOUR RIGHTS

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the following rights with respect to your PHI:

1. **You have the right to revoke any authorization, in writing, any time.**
2. **You have the right to inspect and copy your PHI.** With limited exceptions, you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. You must submit a request in writing. We may deny the request. We may charge a fee for processing costs.
3. **You have the right to request a restriction of your PHI.** You may ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and may say "no" if we believe it would affect your health care. The request must be submitted in writing.
4. **You have the right to request restrictions for out-of-pocket expenses paid for in full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
5. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location or in a specific way**; for example, to use your home or office phone, or to send mail to a different address, and we will agree to all reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the reason for the request. Please make this request in writing.
6. Y**ou have the right to ask us to amend your PHI.** If you believe there is a mistake in your PHI or that an important piece of information is missing in your PHI, you may request an amendment to correct the existing information or add the missing information in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. The request must be submitted in writing.
7. **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** You may request a list of disclosures we have made of your PHI. Your request may cover disclosures for up to six years prior to the date on which you make a the request. This list does not include disclosures for treatment, payment, or healthcare operations, disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. The request must be submitted in writing. We may charge a fee for processing costs.
8. **You have the right to ask us to contact you in a specific way** (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.

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9. **You have the right to obtain a paper copy of this notice from us, upon written request, even if you have agreed to accept this notice electronically.**

VII. COMPLAINTS

Our HIPAA Contact Officer is Jolene Laughlin, DC. Please contact her at 970-673-8486 if you have any questions or concerns referenced in this Notice of Privacy Practices. Additionally, if you believe your privacy rights may have been violated by our office, please file a written complaint with Jolene Laughlin, DC. We will not retaliate or treat you any differently for filing a complaint. Another resource that you may contact is the Secretary of Health and Human Services.

EFFECTIVE DATE OF THIS NOTICE

This notice was revised, published, and became effective on June 22, 2023.

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq. and regulations there under, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that The Homeplace Chiropractic, LLC ("Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand this Chiropractor's Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While this office has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of this Chiropractic office, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

Patient

By: _____ Date: _____

Print Name _____

OR, ON BEHALF OF PATIENT

By: _____ Date: _____

Print Name _____

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