We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we will respect the privacy of your health information. You also acknowledge that you have received or reviewed a copy of our Notice of Privacy Practices. We reserve the right to change our privacy practices as described in that notice and we will advise you in writing of any change.

You have a right to refuse or revoke any of your authorizations 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 receiving your revocation request. 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. 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 restriction on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restriction, the restriction is binding on us. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

By signing this Notice of Privacy Practices, you have authorized Associates in Spinal Relief to disclose your health information in the manner described below:

_____ You are giving us authorization to send the WCA information. We may need to disclose your name, address, phone number, billing information, and your clinical records to the Wisconsin Chiropractic Association (WCA). This disclosure will be made if we need the WCA's assistance to receive reimbursement for your services or, we need the WCA's assistance because the party responsible for reimbursing your services has improperly processed your claim. You may inspect or copy the information we may send to the WCA at any time. You are also authorizing the WCA to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, state or federal agencies that may be asked to intercede on your behalf.

_____ You are giving us authorization to contact you and leave messages on your answering machine or with individuals at your home or place of employment. We may need to use your name, address, phone number, and/or 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 unavailable, a message will be left on your answering machine or with the person answering the phone.

_____ We may need to disclose your health care information in the following circumstances. 1) To another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. 2) Billing records to another party if they are potentially responsible for the payment of your services. 3) Within our practice for quality control or other operational purposes.

You may complain to us or the Secretary of Health and Human Services 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 sent to the address listed below. If you would like further information about our privacy policies and practices please contact:

Associates in Spinal Relief
8081 W. Layton Ave
Greenfield, WI 53220
(414) 282-9001

This notice is effective as of April 1, 2003. This notice will expire seven years after the date upon which you last received services from us. By signing below, I acknowledge that I have reviewed or received a copy of this notice and agree to its terms.

_____ _____
Printed Name Authorized Provider Representative

_____ _____
Signature Date

_____
Date

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.

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer if they are potentially responsible for the payment of your services.
3) Your chiropractor and member of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us this authorization to contact your to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to your or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact your to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Under federal law, We are permitted or required to use or disclose your health information without your consent or authorization in the follow circumstances:

1) To the extent that we are required to do so by applicable federal or state laws.
2) To a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your information under state or federal law.
3) To an appropriate government authority, if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
4) For state and federal health oversight activities of the health care system and government benefit programs.
5) In response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.
6) To a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to comply with court orders, a grand jury subpoena, or administrative requests authorized by law.
7) To an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public.
8) To a correctional institution if we provide health care services to you as an inmate.
9) If we provide health care services to you in an emergency.
10) If we provide care to you that is related to a work place injury to the extent necessary to comply with Wisconsin's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

You may revoke your authorization to us at any time; however your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If there are health care providers, hospitals, employers, insurers or other individuals or organization to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we aggress with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting to make.

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1) Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2) Those disclosures made to you.
3) Those disclosures we are permitted to make without your consent or authorization as described about.
4) Those disclosures made based on an authorization you signed.
5) Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6) Those disclosures for national security or intelligence purposes.
7) Those disclosures made to a correctional officers or law enforcement officers.
8) Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide an accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

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 for all of your health information in our files.

If you have any questions regarding the privacy practices in our facility or would like a copy of the disclosures you have signed at this facility, please mail your request to:

Associates in Spinal Relief
8081 W. Layton Ave
Greenfield, WI 53220
(414) 282-9001