**We Want To Welcome You To Our Clinic**

 And we want to assure you we will do everything we can to correct your spinal problem in the shortest amount of time so it’s most cost effective for you. You will find our atmosphere is not “stiff collar professional” but more “down home” because we treat our patients like family members. Please understand payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read and sign prior to any treatment.

**Full payment is due at the time of service unless other arrangements are made!**

**\*\*We accept cash, check, Mastercard/Visa, Discover and American Express\*\***

We may accept assignment of insurance benefits after your insurance has been verified, and your deductible has been met. However, we require the co-payment portion of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring all current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we will file your insurance for you. If your insurance company does not pay within 45 days, your balance will automatically become due and payable to you. If your company denies any amounts billed by this office, we will provide you with any assistance necessary, but you will be required to contact your company and negotiate with them. Please be aware some and perhaps all of the services provided may be non-covered services, or not be considered reasonable and customary depending on your insurance company.

 Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary.

 The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made for payment, or payment accompanies the minor.

# **Authorization and Assignment**

In consideration of your undertaking me I agree to the following:

 Greenacres Chiropractic Clinic is authorized to release any information they deem appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred at Greenacres Chiropractic Clinic by me.

 I authorize the direct payment to you and of any sum I now or hereafter owe by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges make for your services.

 I authorize Greenacres Chiropractic Clinic to contact my insurance company to attempt to reconcile any problems that may arise if my claims are not paid in a prompt manner. If there is need for any cause of action, I will be responsible for instituting such action. I understand that I am responsible for any and all charges incurred in this office, regardless of what my insurance company pays.

 I have read and understand all of the above.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Greenacres Chiropractic Clinic

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell/Pager #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief complaint/problem(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How and when did symptoms first occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any doctors seen for these problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List diagnosis (es) and type of treatment(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does this interfere with your normal living and work? • Yes • No In what way? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lost any days of work? • Yes • No Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had similar symptoms or injuries before? • Yes • No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the name(s) of any relatives that may have had similar problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a physician treated you for any health condition in the last year? • Yes • No If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include broken bones):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the conditions that you are most interested in getting corrected in order of importance:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Chiropractic Treatment & Acknowledgement of Receipt of Information**

To the patient: Every type of health care is associated with some risk of a potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

 In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

 In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1. **Stroke**: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). (This problem occurs so rarely that there is no conclusion data to quantify probability.)
2. **Disc Herniations**:Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in an increase in low back pain, radicular pain and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.
3. **Soft Tissue Injury**:Soft tissue primarily refers to muscles and ligaments. Muscles move bones, and ligaments limit pain with necessary treatments for resolution, but there are not long-term affects for the patient.
4. **Rib Fractures:** The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

# Consent

I hereby authorize and direct Robert A. Rougeau, D.C., DBA Greenacres Chiropractic Clinic, together with associates and assistants of his/her choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, various modes of physical therapy, x-rays and any additional procedures of service that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_

 Signature of patient or parent/guardian

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have provided and explained the information set forth herein, including any attachments, and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature

**Consent to use PHI**

**Acknowledge for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Greenacres Chiropractic Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day healthcare operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Privacy Protection Policy \_\_\_\_\_\_ (Patient Initials)

**Requesting a Restriction on the Use or Disclosure of Your Information**

* You may request a restriction on the use or disclosure of your Protected Health Information.
* This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
* If we agree to your request, the restriction will be binding with the office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Notice of Treatment in Open or Common Areas**

Some treatment may be performed in an “open” area. Private areas are available to discuss your health information upon request.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legally Authorized Individual Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Full Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**Cancellation Policy:**

**Please respect your appointment time; if you must cancel, 24 hours is required.**

If you are unable to make your appointment, please let us know at least 24 hours in advance. Our clinic maintains a waiting list of patients who would like to be worked into our schedules and we can give them the care they need if we are aware of an open appointment time. Appointments that are missed with no notice or those cancelled with less than 24 hours notice will be billed at the rate of $20.00 which is not billable to insurance.

Please not that if you are more than 15 minutes late, your appointment will be considered a cancellation and you will likely not be able to receive treatment until your next scheduled appointment.

We understand illnesses, accidents, and events happen that can prevent you from keeping your appointment and we will extend a one-time exception for a missed appointment without notification.

My signature below is my acknowledgement that I have read and understand the Cancellation Policy.

Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medication(s)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Known Allergies**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking Status** (circle one)

 **-Current everyday smoker (how many PPD)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **-Former Smoker (when did you start/quit)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **-Never Smoker**

**Current Height** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Weight**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Use Only:**

**Blood Pressure**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Greenacres Chiropractic Clinic

925 Benton Rd

Bossier City. LA 71111

318-747-4433

NOTICE OF PATIENT PRIVACY POLICY

**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.**

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office .

**Our Privacy Officer is Ashley Cooper.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. “Protected Health Information” (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by federal law to abide by the terms of this Notice of Privacy Practices. We change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website [www.greenacreschiropractic.com](http://www.greenacreschiropractic.com), calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**A. Uses and Disclosures of Protected Health Information**

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

**Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent**

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

\* Treatment: We will use and disclose your protected health information to provide, coordinate, or

manage your health care and any related services. This includes the coordination or management

of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

\* Payment: Your protected health information will be used, as needed, to obtain payment for your

 health care services. This may include certain activities that your health insurance plan may under-

 take before it approves or pays for the health care services we recommend for you such as making

 a determination of eligibility or coverage for insurance benefits, reviewing services provided to you

 for medical necessity, and undertaking utilization review activities. For example, obtaining approval

 for chiropractic spinal adjustments may require that your relevant protected health information be

 disclosed to the health plan to obtain approval for those services.

 \* Healthcare Operations: We may use or disclose, as needed, your protected health information

in order to support the business activities of this office. These activities may include, but are not

limited to, quality assessment activities, employee review activities and training of chiropractic

students.

For example, we may disclose your protected health information to chiropractic interns or precepts

that see patients at our office. In addition, we may use a sign-in sheet at the registration desk

where you will be asked to sign your name and indicate your doctor. Communications between you

and the doctor or his assistants may be recorded to assist us when your doctor is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind

you of your appointment. We do have open therapy/adjusting areas.

We will share your protected health information with third party “business associates” that perform

various activities (e.g., billing, transcription services for the practice). Whenever an arrangement

between our office and a business associate involves the use of disclosure of your protected health

information, we will have a written contract with that business associate that contains terms that will

protect the privacy of your protected health information. We may use or disclose your protected

health information, as necessary, to provide you with information about treatment alternatives or

other health-related benefits and services that may be of interest to you. We may also use and

disclose your protected health information for other internal marketing activities. For example, your

name and address may be used to send you a newsletter about our practice and the services we

offer, we will ask for your authorization. We may also send you information about products or

services that we believe may be beneficial to you. You may contact our Privacy Officer to request

that these materials not be sent to you.

**Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

 \* Disclosures of psycho-thereapy notes

 \* Uses and disclosures of Protected Health Information for marketing purposes;

 \* Disclosures that constitute a sale of Protected Health Information;

 \* Other uses and disclosures not described in the Notice of Privacy Practices

 will be made only with authorization from the individual.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor

or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object**

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

\* **Others Involved in Your Healthcare:**  Unless you object, we may disclose to a member of your

 family, a relative, a close friend or any other person you identify, your protected health informa-

 tion that directly relates to that person’s involvement in your health care. If you are unable to agree

 or object to such a disclosure, we may disclose such information as necessary if we determine that

 it is in your best interest based on our professional judgment. We may use or disclose protected

 health information to notify or assist in notifying a family member, personal representative or any

 other person that is responsible for your care of your location or general condition. Finally, we may

 use or disclose your protected health information to an authorized public or private entity to assist

 in disaster relief efforts and to coordinate uses and disclosures to family or other individuals

 involved in your health care.

**Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent,**

**Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent

or authorization. These situations include:

\* **Required By Law**: We may use or disclose your protected health information to the extent that the

 law requires the use or disclosure. The use or disclosure will be made in compliance with the law

 and will be limited to the relevant requirements of the law. You will be notified, as required by law,

 of any such uses or disclosures.

\* **Public Health:** We may disclose your protected health information for public health activities and

 purposes to a public health authority that is permitted by law to collect or receive the information.

 The disclosure will be made for the purpose of controlling disease, injury or disability. We may also

 disclose your protected health information, if directed by the public health authority, to a foreign

 government agency that is collaborating with the public health authority.

\* **Communicable Diseases:** We may disclose your protected health information, if authorized by law,

 to a person who may have been exposed to a communicable disease or may otherwise be at risk of

 contracting or spreading the disease or condition.

\* **Health Oversight:** We may disclose protected health information to a health oversight agency for

 activities authorized by law, such as audits, investigations, and inspections. Oversight agencies

 seeking this information include government agencies that oversee the health care system, govern-

 ment benefit programs, other government regulatory programs and civil rights laws.

\* **Abuse or Neglect:** We may disclose your protected health information to a public health authority

 that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose

 your protected health information if we believe that you have been a victim of abuse, neglect or

 domestic violence to the governmental entity or agency authorized to receive such information.

 In this case, the disclosure will be made consistent with the requirements of applicable federal and

 state laws.

\* **Legal Proceedings:** We may also disclose protected health information in the course of any

judicial or administrative proceeding, in response to an order of a court or administrative tribunal

(to the extent such disclosure is expressly authorized), in certain conditions in response to a sub-

poena, discovery request or other lawful process.

\* **Law Enforcement:** We may also disclose protected health information, so long as applicable legal

 requirements are met, for law enforcement purposes. These law enforcement purposes include (1)

 legal process and otherwise required by law, (2) limited information requests for identification and

 location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a

 result of criminal conduct, (5) in the event that a crime occurs on the premisses of the Practice, and

(6) medical emergency (not on the Practice’s premises) and it is likely that a crime has occurred.

\* **Worker’s Compensation:** We may disclose your protected health information, as authorized, to

comply with workers’ compensation laws and other similar legally-established programs.

\* **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when

 required by the Secretary of the Department of Health and Human Services to investigate or deter-

 mine our compliance with the requirements of Section 164.500 et. seq.

**B. Your Rights**

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

**\* You have the right to inspect and copy your protected health information.** This means you

may inspect and obtain a copy of protected health information about you that is contained in a

designated record set for as long as we maintain the protected health information. A “designated

record set” contains medical and billing records and any other records that your doctor and the

Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administra-

tive action or proceeding, and protected health information that is subject to law that prohibits health

information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our

Privacy Officer, if you have questions about access to your medical record.

**\* You have the right to request a restriction of your protected health information**. This means

 you may ask us not to use or disclose any part of your protected health information for the purposes

 of treatment, payment or healthcare operations. You have the right to restrict certain disclosures of

 Protected Health Information to a health plan when you pay out of pocket in full for the healthcare

 delivered by our office. You may also request that any part of your protected health information not

 be disclosed to family members or friends who may be involved in your care or for notification

 purposes as described in this Notice of Privacy Practices. Your request must be in writing and state

 the specific restriction requested and to whom you want the restriction to apply. You may opt out of

 fundraising communications in which our office participates.

 Your provider is not required to agree to a restriction that you may request. If the doctor believes it

 is in your best interest to permit use and disclosure of your protected health information, your pro-

 tected health information will not be restricted. If your doctor does agree to the requested

restriction, we may not use or disclose your protected health information in violation of that

restriction unless it is needed to provide emergency treatment. With this in mind, please discuss

any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to the staff member identified as

“Privacy Officer” at the top of this form. The Privacy Officer will provide you with “Restriction of

Consent” form. Complete the form, sign it, and ask that the staff provide you with a photocopy of

your request initialed by the staff. This copy will serve as your receipt.

**\* You have the right to request to receive confidential communications from us by alternative**

**means or at an alternative location.** We will accommodate 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 other method of contact. We will not request an explanation

from you as to the basis for the request. Please make this request in writing.

**\* You may have the right to have your doctor amend your protected health information**. This

 means you may request an amendment of protected health information about you 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. Please contact our Privacy Officer if you have questions about

 amending your medical record.

**\* You have the right to receive an accounting of certain disclosures we have made, if any, of**

 **your protected health information.** This right applies to disclosures for purposes other than

 treatment, payment or healthcare operations as described in this Notice of Privacy practices. It

 excludes disclosures we may have made to you, to family members or friends involved in your care,

 pursuant to a duly executed authorization or for notification purposes. You have the right to receive

 specific information regarding these disclosures that occurred after April 14, 2003. The right to

 receive this information is subject to certain exceptions, restrictions and limits.

**\* You have the right to be notified by our office of any breech of privacy of your Protected**

**Health Information.**

\* Certain treatments may be performed in a common therapy area and/or you may find yourself

 within public areas within the clinic times, but please note private rooms are always available,

 upon request, for discussing your private health information.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed

to accept the notice electronically.

**C. Complaints**

 You may complain to us, or the Secretary of Health and Human Services, if you believe your

 privacy rights have been violated by us. To file a complaint you may go to:

 <http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplainform.pdf>

 Or our office can provide you with a written form in which to file your complaint. You may also file

 a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against

 you for filing a complaint.

 Our Privacy Officer is **Ashley Cooper**; you may contact our Privacy Officer, or any

 staff member, including Dr. Rougeau at the following phone number **318-747-4433**

 or our website [www.greenacreschiropractic.com](http://www.greenacreschiropractic.com) for further information about the

 complaint process.

This notice was published and becomes effective on 4/1/2018.