Jackson Family Chiropractic

Patient Privacy Notice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes- to obtain payment from your insurance company or any other collateral source.
4. For workers compensation or personal injury purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For public health and safety- in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement- to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons- discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls, texts, or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice was ever sold the new owners would have access to your personal health information.
12. Outsourced Billing- this office uses the services of Medical Billing Associates of Florence for billing matters including, but not limited to, cash, insurance and 3rd party billing. This office and MBA may use secure emails and phone calls to discuss billing matters that pertain towards your account.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To request mailings to an address different than residence.
3. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
4. To inspect your records and receive one copy of your records at no charge, with notice in advance.
5. To request amendments to information, however like restrictions we are not required to agree to them.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made we will be happy to accommodate you however you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please contact our office directly. If you are still not satisfied with the manner in which this office handles your complaint you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Patient Privacy Policy" at a time in the future and will make the new provisions effective for all information that it maintains past and present. At this time I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
(Print) Patient Name	Patient Signature	Date
_____	_____	_____
(Print) Witness	Witness Signature	Date

Jackson Family Chiropractic, P.C.
1025 West Carolina Avenue
Hartsville, SC 29550
Phone: 843-332-6151
Fax: 844-270-8009

Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____	_____	_____
Patient Signature	Printed Patient Name	Date