CHIROPRACTIC CENTER OF NEW BRITAIN
DR. FRANCIS J. VESCI
10 CEDAR STREET
NEW BRITAIN, CT 06052
PH: (860) 225-9925 • FX: (860) 229-1129

OUR PRIVACY POLICY

Notice of Privacy Practices

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. If you have any questions or concerns or require additional information after reading this Notice of Privacy Practices, or if you believe that your privacy has been compromised in any way, please contact us immediately.

About this Notice of Privacy Practices

We are required by law to maintain the privacy of your Protected Health Information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice") explaining our privacy practices with regard to your PHI. "Privacy practices" refers to the ways in which we may use and disclose your PHI. This Notice explains your rights and our legal obligations regarding the privacy of your PHI. We are required by law to abide by the terms of this Notice. We are also required by law to notify you following any breach of privacy of your PHI. If you are a minor, or otherwise incapacitated, we will notify your parent/guardian, or other person responsible for you.

What is PHI?

PHI is information that individually identifies you which we create or obtain from you or another health care provider or health plan, your employer, or a health care clearinghouse, and which relates to (1) your past, present, or future physical or mental health conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

There are several circumstances in which we may have to use or disclose your Protected Health Information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operational purposes (i.e. we may use your e-mail to send you general health-related information such as newsletters, exercises, personal contact, paperwork, etc.)

You have the right to look at or get copies of your health information, with limited exceptions:

- We will use the format you request unless we cannot practicably do so. (You must request in writing to obtain access to your health information or through a Release of Records Form provided by our office or a separate physician's office.)
- By law, we have up to 30 days to provide the records requested.
- Records may be requested with no extra cost or fees unless more than one copy of each record is requested. Reimbursement for the cost of more than one copy of records in accordance with Section 20-7 (c) of the Connecticut general Statutes is **$0.65** per page and the cost of first-class postage OR ***$15.00*** per hour for staff time to locate and copy your health information. Payment will be due upon request and a consent form will be provided.
- All records are kept for 7-11 years, anything after may be lawfully destroyed. All records prior to December 31, 2011 may not be available for disclosure.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to certain individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions if they put you or someone else at risk or other medical emergencies.

Your Right to Revoke Your Authorization

Right to Revoke Your Authorization. You may revoke any authorization you have provided by providing a written revocation to our Office Manager. However, such revocation does not apply to uses or disclosures made in reliance on authorization given prior to revocation. To exercise your rights as described in this Notice, send your request, in writing, to our Office Manager at the address listed at the top of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your PHI, you may also contact your practitioner directly. To get a paper copy of this Notice, contact our Office Manager by telephone, electronic mail, or regular mail.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of Chiropractic Treatment: The doctor will perform an examination and different range-of-motion tests, if necessary, to determine a diagnosis and make treatment recommendations. If a treatment is initiated, the doctor will use his/her hands to perform spinal manipulation which may be done through manual movements or mechanical instruments to help bring mobility to the neck, back, shoulders, etc. A mechanical device or manual movements may be used in an attempt to restore normal function to your joints and muscles. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or other soft tissue techniques may also be used to help further relax the symptomatic areas.

Posture Screening: A Posture Screening is an electronic photograph taken, ONLY WITH YOUR CONSENT IN THE FORM OF YOUR INITIALS AND SIGNATURE BELOW, to demonstrate to you exactly what your posture looks like from a front-facing and side-facing view. It will demonstrate how it is affecting you and your current symptoms/complaints. The Posture Screening is or may be done once at every EXAM, RE-EXAM, FINAL EXAM or IF AND WHEN THE DOCTOR DEEMS IT NECESSARY to check on your progress. The electronic photograph will NOT be released to anyone other than yourself and the medical staff in this office.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation and/or ancillary procedures. Extremely rare complications could include muscle strain, ligamentous sprain, injury to intervertebral discs, rib fracture, or nerve injury. A small minority of patients may notice stiffness or soreness with the first few treatments. The ancillary procedures/hot packs could produce skin irritations, bumps, or minor complications. (These have an extremely low incidence, especially when spinal manipulation is administered properly).

Other treatment options which could be considered may include the following:

- *Acupuncture*. This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort, usually achiness or soreness. Other possible risks in acupuncture include dizziness and fainting. Rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) including fainting, nerve damage, organ puncture (pneumothorax) and infection.
- *Over-the-counter analgesics*. The risks of these medications include irritation or damage to the stomach, liver, kidneys, ulcers or other side effects in a significant number of cases. A Doctor of Chiropractic is not licensed to prescribe medication.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and cause chronic pain cycles. It is quite probable that a delay of treatment will complicate your condition and make future rehabilitation more difficult.

Chiropractic Treatment

- ☑ I have read the explanation above about different **CHIROPRACTIC TREATMENTS**.
- ☑ I have fully evaluated the risks and benefits of undergoing treatment.
- ☑ I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Initial: _____

Posture Screening

- ☑ I have read the explanation above about a **POSTURE SCREENING**.
- ☑ I understand the above-mentioned information and agree to have my photograph electronically taken for the sole purpose of my posture & health.

Initial: _____

Healthcare Insurance

- ☑ I understand that all services are to be paid in full at the time of service in accordance with my Medical Insurance policies (CO-PAY, CO-INSURANCE, DEDUCTIBLE, POSSIBLE DENIALS).
- ☑ I understand that my Medical Insurance may not cover all my visit(s) and I am responsible for any Non-Covered service(s) (CO-PAY, CO-INSURANCE, DEDUCTIBLE, POSSIBLE DENIALS).
- ☑ I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for my own payment.
- ☑ I understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.
- ☑ I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
- ☑ I authorize the use of the signature at the end of this form on any insurance submissions.

The patient certifies that he/she has read and agreed to the forgoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's power of attorney to execute the above and accept its terms.

_____ _____ _____

PATIENT Signature | Signature of GUARDIAN, if other than PATIENT | Date

_____

PATIENT NAME – Please Print