

Brian Larsen, DC
dba Larsen Chiropractic & Rehab
NOTICE OF PRIVACY PRACTICES

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.

Brian Larsen, DC dba Larsen Chiropractic & Rehab is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. (example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Brian Larsen, DC dba Larsen Chiropractic & Rehab”

“It is our policy to provide a substitute health care provider, authorized by Brian Larsen, DC dba Larsen Chiropractic & Rehab to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Brian Larsen, DC dba Larsen Chiropractic & Rehab for health care services rendered. If you pay your health care services personally, we will, as a courtesy provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnoses, date of injury or condition, and codes which describe the health care services rendered.”

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner, and government benefits purposes.

Marketing

We may contact you for marketing purposes as described below: (example)

“We may contact you, by the method of your choice; home/work/cell telephone number, text messaging, mail, and/or e-mail if you miss a chiropractic, massage, or therapy appointment. We may also contact you to check the status of your condition or as a

reminder of a massage or therapy appointment. If you do not answer the telephone, we will leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office with your status or to schedule a new appointment.”

“A periodic newsletter by e-mail and/or mail for the purpose of education will be sent out to our patients who choose to participate.”

“You may receive an occasional postcard or card from Brian Larsen, DC dba Larsen Chiropractic & Rehab as a thank you for a referral or for other occasions and reasons.”

Change of Ownership

In the event that Brian Larsen, DC dba Larsen Chiropractic & Rehab is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Brian Larsen, DC dba Larsen Chiropractic & Rehab is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Brian Larsen, DC dba Larsen Chiropractic & Rehab amend your protected health information. Please be advised, however, that Brian Larsen, DC dba Larsen Chiropractic & Rehab is not required to agree to amend your protected health information. If you request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Brian Larsen, DC dba Larsen Chiropractic & Rehab.

Your have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Brian Larsen, DC dba Larsen Chiropractic & Rehab reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Brian Larsen, DC dba Larsen Chiropractic & Rehab is required by law to comply with this Notice.

Brian Larsen, DC dba Larsen Chiropractic & Rehab is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Bonnie Van Sickle by calling this office at 530-885-4447. If neither is available, you may make an appointment for a personal conference in person or by telephone with 2 working days.

Complaints

Complaints about your Privacy rights or how Brian Larsen, DC dba Larsen Chiropractic & Rehab has handled your health information should be directed to Bonnie Van Sickle by calling this office at 530-885-4447. If neither is available, you may make an appointment for a personal conference in person or by telephone with 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S. W.
Room 509F HHH Building
Washington, DC 20201

Incidental Disclosure(s) of PHI

I. Overheard Discussion/Conversation

Due to the nature and volume of the practice, discussions/conversations between you and the doctor, or you and a member of the staff, or the doctor and his assistants involving your PHI, may at times be overheard by other patients.

II. Encounters with Other Patients

Due to the nature and volume of the practice, you may be: A.) seen by other patients as you receive treatment, either in a treatment room or in the rehab area and it's environs, in a way that could compromise the privacy of your PHI, or B.) seen by other patients entering or exiting from the office, or in the waiting room and it's environs, including halls, which could by virtue of your physical condition and/or presentation, compromise the privacy of your PHI.

This notice is effective as of _____ / _____ / _____ .

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Brian Larsen, DC dba Larsen Chiropractic & Rehab with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's Name (PRINT)

Patient's Signature

Date

Authorized Facility Signature

Date

Rev. 8/2013

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

Mailing Address.

If appropriate, please contact me at the following address:

Phone.

If appropriate, please contact me by telephone at the following number:

Fax.

If appropriate, please contact me by fax at the following number:

E-Mail.

If appropriate, please contact me by E-mail at the following E-mail address:

**I have the following additional requests for confidential communications regarding my Protected Health Information:
(Please explain)**

I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.

Signature Date

Accepted as requested. Modified as noted: _____

Authorized Signature of Facility Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of ~~Larsen~~ **Larsen Chiropractic & Rehab's** "NOTICE OF PRIVACY PRACTICES," revision date 8/2013.

As required by the Privacy Regulations, **BRIAN LARSEN D.C.** from
Name of Staff Member

LARSEN Chiropractic & Rehab has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that ~~Larsen~~ **Larsen Chiropractic & Rehab** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information.
- I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- I wish to object to the following in the "Notice of Privacy Practices:"

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Signature Date

Print Name

(OFFICE USE ONLY) _____
BRIAN LARSEN D.C.

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

