

**Windham Chiropractic and Rehabilitation  
Privacy Notice Summary**

(A copy of the complete Windham Chiropractic and Rehabilitation Notice of Privacy Practices is available to be read in our office waiting room or you may request that we give a copy to you.)

This notice describes and gives examples of how chiropractic and health information about you/your child may be used and disclosed and how you can get access to this information. REVIEW IT CAREFULLY. Federal Law requires us to:

- < Make sure that health information that identifies you is kept private.
- < Give you this notice of our legal duties & privacy practices with respect to health information.
- < Follow the terms of the notice that is currently in effect.

**Examples of how we may use and disclose health information about you:**

**For TREATMENT purposes we may use and disclose your health information**

- < To another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- < To members of your treatment team such as your physician or specialist.
- < To a family member, friend or other person only to the extent necessary to help with your care or payment for your care.
- < To contact you regarding appointment reminders, information about alternatives to your present care, or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications & to request restrictions relative to such contacts & to be contacted by alternative means or at alternative locations.
- < To a Business Associate (an entity that assists the practice in undertaking some essential function) if we obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your private health information.

**For PAYMENT purposes we may use and disclose health information about you**

- < To another party, such as an insurance carrier, an HMO, a PPO., or your employer, if they are responsible for the payment of services provided to you.
- < When we process payment by credit card.
- < When we try to collect unpaid amounts through collections agencies.

**For HEALTHCARE OPERATIONS**

- < In the case of financial or billing audits.
- < In the case of internal quality assurance, review of practitioners and credential activities.
- < To contact you for an appointment reminder, schedule change, or other related information.
- < The Practice may use & disclose health information that may be related to your care but does not identify you & cannot be used to identify you.

**We are permitted and may be required to use or disclose your health information without your authorization in the following circumstances:**

- < To governmental authorities about victims of suspected abuse, neglect or domestic violence.
- < In response to subpoenas, court orders, or administrative agencies. < If we provide health care services to you in an emergency.
- < If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- < If there are substantial barriers to communication with you, but in our professional judgement we believe that you intend for us to provide care.

**Patient Rights:** We will not use or disclose your protected health information for marketing purposes which we have accepted payment without your express written permission. However, we may contact you with information about products, services, or treatment alternatives directly related to your treatment and care. You may request that we restrict how we disclose your health information for treatment, payment, or health care operations. We are not required to agree to this request. If we do agree, we will comply with this request except in the case of an emergency. You may request that we communicate your health information with you in a certain way. You may request to review or get photocopies of your health information. This request must be in writing. You have the right to revoke any authorization or consent you have given the practice, at any time. You must do so in writing. You have the right to request an accounting of disclosures we have made regarding your protected health information. You have the right to complain if you believe your privacy rights have been violated. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, DC 20201.

My signature acknowledges that I have been offered a copy of this notice.

\_\_\_\_\_  
Name (Printed Please)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date