

LaVallee Chiropractic and Family Wellness

HIPPA & Open Adjusting Consent Form

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Before we can begin any health care for you we require you to read and sign this consent form stating that you understand these policies and practices. If you do not sign this consent form, we reserve the right to refuse to provide you care in our office.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Your signature below indicates that you understand and agree to allow this chiropractic office to use your health information for the purposes of treatment, payment, practice operations, and coordination of care. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may request restrictions on disclosures.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment which involves patients being treated in a public area within our office where they can be seen by one another and others in our office and building. Some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for patient histories, examinations, or reports of findings. These procedures are completed in private. If you choose not to be adjusted in an open adjusting environment, other arrangements will be made for you.

Your consent on this form need only be obtained one time for all subsequent care provided to you by this office. You may provide a written request to revoke your consent at any time during your care. This would not affect the use of those records for any care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

Your signature on this form also allows this office to use your name and case for certain internal purposes, including but not limited to, sign in sheets, welcome and referral boards, success stories and testimonies, case studies, pictures, etc. You further agree that we may contact you for appointment reminders and follow-up, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I have read and understand how my health information will be used by this office and I agree to these policies and procedures.

(Signature)

(Date)