

The Neck, Back, Arm, Leg, and Headache

PAIN RELIEF CLINIC OF MARIN

www.painreliefclinic.net

415-444-0700

San Rafael, CA 94903

Welcome- we protect your personal information

The Chiropractic Office of Dr. Michael Joseph

Patient Authorization for appointment reminders and scheduling related matters and contact regarding chiropractic care, related health services and/or related health products.

It is our desire to for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues and to advise you about health related meetings, workshops, and products.

The use of this information is held in the strictest confidence by us and will not be used for any other purpose and is intended solely to make your experience with our office more efficient enjoyable and productive. If you feel that it is not in your best interest to authorize this, then, it will have no adverse effect on your actual care from us.

Your signature indicates your authorization of these activities.

Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization.

The Chiropractic Office of Dr. Michael Joseph

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at the office of Dr. Michael Joseph DC we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or

disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*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 communicating with you, but in our professional judgement we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request

an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Joseph. If you would like further information about our privacy policies and practices please contact: Dr Joseph.

This notice is effective as of _____. This notice, and any amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

Personal Representative Printed Personal Representative Signature Date
Description of the authority to act on behalf of the patient.