PATIENT POLICIES AND CONSENT

NOTICE OF PRIVACY RULES

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

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and the privacy practices described below while this Notice is in effect. This Notice is effective as of _____, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEATLH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations, Examples of these activities are as follows:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing you treatment.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection without healthcare operations. Healthcare operations include quality assessment and improvement, activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while was

in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. ELECTRONIC NOTICES: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information, you may complain to us using the contact information listen below, You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to: Contact: Robert L. Jackson D.C

Telephone:717-558-8110 Fax:717-558-8115
E-mail: rljchiro@yahoo.com

I have read the foregoing and understand my rights under the Protected Health Information provision of HIPAA.

OFFICE PROCEDURES

1. **Medical Emergency:**

   If a medical emergency occurs, dial 911 for EMS support and provide all pertinent information.

   Administer first aid, CPR, or other appropriate procedures to the limit of your training and experiences.

   Office staff must notify the doctor on the premises.

   Document the event in a clear and concise manor.

2. Patient Scheduling:

A patient must be able to schedule a routine appointment within seven (7) days; and

A patient should not have to wait more than thirty (30) minutes, on the average, following the appointment time prior to being seen.

An answering machine message directing patient to call the doctor at home or on his cell phone will be available when the office is closed.

3. Evacuation Plan:

In an emergency that requires evacuation, lead occupants out the door, turn left and exit the main entrance. If this exit is blocked, unlatch any window and exit the building.

Occupants should be aware of alarm signals that tell them to evacuate.

Exit lanes should be free of clutter or obstructions.

The front desk workers are responsible for making sure the front of the office is vacant. The doctor will be responsible for making sure the back of the office vacant.

4. In the event of a robbery or other threatening behavior, follow steps below:

Cooperate as much as possible.

If you are not being held, run as fast as you can away from the threatening person.

Contact "911" if possible.

Remember to observe all aspects of the person who is threatening you; clothing, height, weight, coloring, and other distinguishable features for later identification.

Office staff must notify the doctor on the premises, and the event will be documented.

5. Patient Confidentiality

Medical records are to be stored in lockable file cabinets. Records are to be clearly indexed and filed alphabetically.

Patients are to read a Notice of Privacy Rules form and informed consent form and sign that they have read the information.

Unless its release is authorized by the patient or compelled by law, all information about the patient gathered by the practitioner as any part of the doctor-patient relationship is kept confidential.

Billing and financial records are computerized and only available to stay with password clearance.

Treatment records are computerized separate from billing records on a secure system in the provider's private office.

All computers in office with internet access will have firewall and antivirus programs to thwart unauthorized access.

6. Non-Compliance with Clinical Advice:

All clinical advice including diagnosis or treatment recommendations and self-care measures is to be recorded in the medical chart.

If the patient proves to be non-compliant with clinical advice after three (3) documented reminders or (2) weeks of care, doctor or support staff will call the patient and provide instructions specific to their case.

7. Missed Appointments:

After three (3) missed appointments without a phone call, remove patient from schedule. Office staff should call patient to advise them of this.

8. Financial Policy:

Claims denied by the patient's insurance carrier may be the responsibility of the patient. Payment plans will be made available if necessary, and care will be made affordable.

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Provider: Dr. Robert Jackson- Harrisburg Area Chiropractic, 7980 Grayson Road, Harrisburg PA

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I acknowledge that on occasion the information my insurance company provides to Harrisburg Area Chiropractic staff is incorrect or incomplete.

I acknowledge that I am responsible for any additional charges that may be added after claims are submitted and processed.

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To All Physicians, Hospitals and Other Health Care Providers Who Have Provided Care, Treatment or services and / or Insurance Companies Who Have Provided Benefits to Patient:

I hereby authorize Harrisburg Area Chiropractic, and persons acting on its behalf, to receive information, and examine and receive copies of all records of every sort and kind, regarding the medical status of the patient named below. Such information and records are required in order to evaluate the condition of the patient. A photocopy of this authorization is to be considered as effective and valid as the original.

I understand that the medical information and records disclosed pursuant to this authorization may be redisclosed by the receiving entity for any lawful purpose, and thereafter, may no longer be protected by federal law privacy rules. I understand this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information, However, I understand any such revocation will not have effect on any action the providing entity took prior to receiving the revocation.

Please fax all records to 717-558-8115 or mail to above address.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____