Dr. Amanda Thompson, D.C. PAK

HIPAA/Privacy Policy Notice

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, is kept in proper confidentiality. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain privacy of your health information and how we may use and disclose your health information. This practice is committed to maintaining the privacy of your protected health information, which includes information about your health conditions as well as the care and treatment you receive from this practice.

With Consent, the practice may use and/or disclose your personal health information provided that we first obtain a valid Consent Form signed by you. The Consent Form will allow the practice to use or disclose your personal health information for the purpose of:

- Treatment- providing, coordinating, or managing health care and related services by one or more health care providers. This includes consultation between health care providers relating to a patient, and the referral of a patient for health from one health care provider to another. An example of this includes the results of a physical examination.
- Payment- activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill or progress report to your insurance company for payment.
- Health care operations- includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us your authorization, you may revoke it at any time.

Without consent, we may use or disclose your personal health information in the following instances:

- De-identified information- information that does not identify you and cannot be used to identify you.
- Family and friends- disclosure of 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, but only if you agree that we may do so, or if you are not able to agree, if it is seen as necessary in our medical judgment.
- Persons involved in care- includes notifying a personal representative, communicator, family member, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosures of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event that you are incapacitated or in emergency circumstances, we will disclose health information based on a determination using our professional judgment. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a

person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

- Abuse or neglect- disclosure of health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- Required by law- disclosure of your personal health information when we are required to do so by law, including judicial and administrative proceedings.
- National Security- disclosure to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody or protected health information of inmate or patient under certain circumstances. We may also disclose information to a public health authority, or as authorized by law, to prevent or control disease.
- Organ, eye, or tissue donations- disclosure of personal health information, if you are an organ donor, to the entity with whom you have agreed to donate your organs.

The practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Appointment reminders may include phone calls, voicemail messages, postcards, e-mails, or text messages.

Your Rights

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to review or get copies of your health information, with limited exceptions.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information. We may deny your written request under certain circumstances.
- The right to receive an accounting or disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Practice's Legal Duty

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services,

Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Contact: Dr. Amanda Thompson or Dr. Brice Miller
Synergy Chiropractic, LLC
932 Hungerford Drive Suite 12A
Rockville, MD 20850
Phone: 301-637-9248 Fax: 240-386-8285
E-mail: dramanda@ synergychiros.com
drbrice@synergychiros.com

By signing this notice, you certify that you have read the HIPAA/Privacy Policy Notice for Synergy Chiropractic as well as understand and agree to the terms and conditions that apply to your privacy as a patient at Synergy Chiropractic.

Patient Name ____________________________ Legal Representative __________________________

Legal Representative / Patient's Signature ______________________________ Date ________________ SC, LCC only initials _______