Ford Chiropractic, Inc.
1304 North Main Street
LaFayette, GA 30728

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 Ford Chiropractic, we may use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider of hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your medical 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 responsible for the payment of your services.
3. Your name, address, phone number, and your medical 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.
4. We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your medical care.
5. We may disclose your health information in response to a court or administrative order, a valid subpoena, discovery request, civil/criminal proceedings or other lawful process.
6. We may release your health information for workers' compensation benefits or to similar programs that provide benefits for work-related injuries or illness.

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 barrier to communicating with you, but in our professional judgment 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 address 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 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. Aaron Ford

This notice is effective April 14, 2003. This notice and any alterations or 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.

I hereby authorize the following: (Please Initial All That Apply)

_____ Release of medical information to other medical providers, by phone, in person, or by mail as necessary for continued care process.

_____ Release of medical information to other medical providers, as necessary, VIA FAX, as requested by them.

_____ Release of medical information, as necessary, VIA FAX, INTEROFFICE COURIER, IN PERSON, OR BY MAIL for claims/billing processes.

_____ Voicemail messages on my personal phone/answering on my personal phone/answering machine regarding appointments/callbacks, etc.

_____ I authorize, as necessary, test results, appointments, etc. to be given to _____ who is my _____ (relationship to person named) in my absence.

_____ _____ _____

Patient Name (Printed) Patient Signature Date

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

_____ _____ _____

Personal Representative (Printed) Personal Representative Signature Date

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Description of the authority to act on behalf of the patient

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Patient Signature (or parent/guardian if minor) Date