North Suburban Chiropractic and Acupuncture

Notice of Privacy Practices
Health Insurance Portability and Accountability Act (HIPAA)

This notice summarizes how health data about you may be used and shared and how you can get to this data.

How we may use and share health data about you:

- •Treatment: To give you medical treatment or other types of health services.
- •Payment: To bill you or a third party for payment for services provided to you.
- •Health Care Operations: For our own operations such as quality control, compliance monitoring, audit, etc.

Disclosures where we do not have to give you a chance to agree or object:

- •To you
- •As required by federal, state, or local law
- •If child abuse or neglect is suspected
- •Public health risks (for public health activities to prevent and control spread of disease)
- •Lawsuits and disputes (in response to a court or administrative order)
- •Coroners, medical examiners and funeral directors
- •Organ or tissue donation facilities if you are an organ donor
- •To avert a threat to an individual or to public health safety

Disclosures where we have to give you a chance to agree or object:

- •Patient directories: You can decide what health data, if any; you want to be listed in patient directories
- •Person involved in your care or payment of your care: We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

Other uses of health data: Other uses not covered by this notice of the law that apply to us will be made only with your written consent.

You have the following rights relating to the heath data we keep about you:

- •Right to inspect your health record and to receive a copy of your health record upon request
- •Right to amend information in your health record you believe is inaccurate or incomplete
- •Right to ask for limits on the health information data we give out about you
- •Right to receive communication from us about your health information in alternate ways
- •Right to a paper copy of the complete notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

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Signature or patient or representative Date

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Print patient name Patient Date of Birth