Foxworth Chiropractic
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Our practice is dedicated, and applicable federal and state laws require us, to maintain the privacy of your health information. These laws require us to provide you with Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is in effect as of April 2003, 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 policy 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 the Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any 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 forward your complaint to us using the contact information listed 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 questions or complaints to:
Foxworth Chiropractic
2470 Flowood Drive, Suite 125
Flowood, MS 39232
Phone: 601-932-9201
Fax: 601-932-4962
E-mail: CCCms@aol.com

ACKNOWLEDGEMENT OF AVAILABILITY OF FULL PRIVACY PRACTICES

I, _____, (Name of Patient) acknowledge that I have been advised that Foxworth Chiropractic will provide me, upon request, a full Notice of Privacy Practices, which describes the Practice's policies and procedures regarding the use and disclosure of any Protected Health Information created, received, or maintained by the Practice.

Date: _____

Print Name: _____ Signature: _____

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NOTICE OF PRIVACY PRACTICES
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ (Name of Patient), consent to Foxworth Chiropractic's (the Practice's) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but are not limited to quality assessment activities, credentialing, business management, and other general operations activities. *These operational activities include providing an initial report or progress reports regarding my treatment/diagnosis and progress notes to my former, current, or any future physicians that I may be referred to by this practice.* I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, and future physical and mental health or condition; the provision of health care to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or Practice has acted in reliance on this consent.

CONSENT FOR OTHER COMMUNICATIONS AND PRACTICE POLICIES UNRELATED TO TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Our office will from time to time mail a practice newsletter, post-cards, thank-you letters to whomever may have referred you to our practice, and other written and electronic communications to keep you informed about our practice, your condition, the conditions we treat, and general health information. We may also, with your permission, recognize you on our Thank You for Referring Bulletin Board, or other in office Bulletin Boards, if you have referred a patient to us for care, have a birthday or anniversary, or we feel recognition is in order, due to your goodwill toward the practice or others. You have the right to "opt-out" of these communications and recognitions by checking the appropriate line below.

I would like to "opt-out" of the items noted below.

___ Practice newsletter, post-cards, thank you letters, thank you for referring letters, and other written and electronic communications to keep you informed about our practice, your condition, the conditions we treat, and general health information.

___ Please do not recognize me in the practice newsletter or in office bulletin if I have referred a patient to you for care, or have a birthday or anniversary, or you feel recognition is in order due to my goodwill toward the practice or others.

Date: _____
Signature of Patient or Representative _____
Printed Name of Patient or Representative _____
Description of Representative's Authority _____

REVOCATION OF CONSENT

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or Practice has acted in reliance on this consent. By my signature below, I hereby REVOKE this consent, effective (date) _____.

Print Name: _____ Signature: _____
Witnessed by:
Print Name: _____ Signature: _____

Signature of Personal Representative: _____ Date: _____
Printed Name of Patient or Representative: _____
Description of Personal Representative's Authority: _____