CLEGG CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

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

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice or our privacy practices. You have the right to the confidentiality of your medical information and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect; and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the privacy officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical records, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries and business associates may share medical information with each other for treatment, payment purposed of healthcare operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways we may use and disclose medical/chiropractic information without your specific consent or authorization. Examples are provided for each category of used or disclosures. Not every possible use of disclosure in a category is listed.

For Treatment: We may use medical information about you to provide you with chiropractic treatment or service. Example: In treating you for a specific condition, we may need to know if you have had surgery on the area being treated.

For Payment: We may use and disc lose medical/chiropractic information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, and insurance company, or a third party. Example: we may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical/chiropractic information about you for health c are operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent of Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by Military Command authorities for their medical records
- To workers' compensation or similar programs for processing claims
- In response to a legal proceeding
- To a coroner or medical examiner to identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the U.S. Food and Drug Administration (FDA)

We may 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.

Uses and Disclosures of Protective Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use of disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care we have provided you.

CLEGG CHIROPRACTIC, P.C.
225 LOUDOUN ST, SE
LEESBURG, VA 20175

PHONE (703)777-8884
FAX (703)777-9071

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Patient name:_____

Date of Birth:_____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the rights to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident, or controlled by this practice. If changes to the policy occur, this practice will provide a revised Notice of Privacy Practices upon request.

Signature:_____

Date:_____

_____

Relationship to patient (if signed by a personal representative of patient)