HIPAA Statement

Pudenz Family Chiropractic Clinic will identify and evaluate the likelihood and consequences of threats to the security of Protected Health Information and implement reasonable and appropriate measures to safeguard the confidentiality, availability, and integrity of that information. PCC will adopt and implement HIPAA security practices outlined in the approved HIPAA Security Procedures.

Pudenz Family Chiropractic Clinic will safeguard information in a manner consistent with applicable requirements of federal, state and local law and regulations, including the final rule governing the security of health information systems enacted by the Department of Health and Human Services as required by HIPAA.

Uses and Disclosures of Your PHI

The following sections describe different ways that we may use and disclose your PHI. For each section of uses or disclosures, there will be a description given. Not every use or disclosure will be listed.

Treatment

We may disclose your PHI to another healthcare provider, transport company, community agency, family member or other third party to provide and/or coordinate health care services and treatments.

Payment

We may use and/or disclose your PHI to bill and obtain payment for treatment and/or services you receive at Pudenz Family Chiropractic Clinic.

Appointment Reminders

We may contact you to remind you that you have an appointment at our clinic.

Individuals Involved in Your Care or Payment

Unless there is a specific request made to and agreed to by the Privacy Officer at your location, we may disclose PHI to a person who is involved in your health care or helps pay for your care, such as a family member or friend to facilitate that person's involvement in caring for you or in payment for your care.

Disaster Relief Efforts

We may disclose your PHI to an entity assisting in a disaster relief effort so your family can be notified about your condition, status and location.

As Required by Law

We will disclose health information about you when required to do so by federal or state law.

Public Health Purposes

We may use or disclose your PHI when we are required to do so by law, for public health reasons, including, but not limited to: Reporting certain communicable diseases to health officials, reporting child abuse or neglect, reporting elder abuse, neglect or exploitation.

Lawsuits and Other Legal Actions

We may disclose PHI in response to judicial proceedings and law enforcement inquiries as permitted by law. We may also disclose PHI in response to a subpoena, discovery request, warrant, summons or other lawful process.

Worker's Compensation

We may disclose PHI as necessary for workers' compensation or similar programs that provide benefits for work-related injuries or illness, as authorized or required by law.

Other Uses of PHI

Other uses and disclosures of PHI not covered by this notice or that laws what apply to us will be made only with your written authorization.

Your Rights

Access to Your PHI

You have the right to access, inspect, and/or receive paper and/or electronic copies of the PHI that we maintain about you, with limited exceptions. Pudenz Family Chiropractic Clinic provides to an individual, upon written request, access within 30 calendar days of the day the Clinic receives a request, to inspect and/or copy their PHI. If you request paper copies, we will charge you our standard copying fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your PHI in that format. If you prefer, we will prepare a summary or an explanation of your PHI for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

Restrictions on Use and Disclosure of Your PHI

You have the right to request that we place additional restrictions on our use or disclosure of your PHI for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios.

Amendments to Your Records

You have the right to request that we amend your PHI. Such requests must be made in writing, and must explain why the information should be amended. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing and signed by you or your representative, and must state the reasons for the amendment' correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please note that even if we accept your request, we may not delete any information already documented in your health records.

Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

Changes to this 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 privacy 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 PHI created or received by us prior to the date of the changes.

Additional Information

Complaints

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 make a formal complaint in writing to us. You may also submit a written complaint to the U.S. Department of Health and Human Services in Washington D.C. All complaints must be made in writing and in no way will affect the quality of care you receive at our clinic.

Breach Notification

We are required to notify you in writing of any breach of your secured PHI as soon as possible, but in any event, no later than 60 days after we discover it.

Paper Copy of this Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you received this notice electronically, you are still entitled to a paper copy.

INSURANCE BENEFITS-CREDIT POLICIES-PAYMENT TERMS & CONDITIONS

1. Pudenz Family Chiropractic will file initial insurance claims for you.
2. If your insurance requires a pre-authorization for any services, please make us aware, as you may be liable if this was not obtained. You are considered to be a "cash" patient until we verify your coverage to determine the extent of benefits under your policy.
3. Co-pays, deductibles, and all non-covered services are due the day the service is rendered.
4. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse Pudenz Family Chiropractic enough to meet our cost of service.
5. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment in not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed to Pudenz Family Chiropractic for any & all treatment, products, & services rendered to the patient or minor shown below.
6. A service charge is computed by a 'periodic rate' of 1 ½% per month-18% per annum & is added to all balances owed 90+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interests, costs related to but not limited to all collection related expenses, attorney fees, court &filing fees. Returned checks, debit & credit charges made payable to Pudenz Family Chiropractic for insufficient funds, stop payments, or other reasons on non-payment will be assessed a $30.00 charge.
7. Medicare Patients: Please understand that there is a calendar year deductible and you are personally responsible to pay that until met if your supplemental insurance won't cover it. Thereafter, Medicare will pay for the adjustment only. Any remaining balance will also be your responsibility if your supplemental doesn't cover the charges.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of any proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. The event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorizes you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company contractually obligated, you will refrain from collecting the amounts owed, directly from me .I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due; I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statue of limitations on collection and recovery in the State of Iowa
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effect until revoked by both parties.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies, & Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

____________________ ______________________________________

DATE SIGNATURE OF PATIENT/GUARDIAN