

Harbour Healthcare, Inc.

719 High Street, Suite 118

Portsmouth, VA 23704

(PHONE) 866.601.4443

(FACSIMILE) 866.596.6056

www.myharbourhealthcare.com

HIPAA- Health Care Portability and Accountability Act

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

*Your personal health information, including all of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care 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 or may be responsible for the payment of your services.

*Your name, address, phone number, and your health care 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.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine, voice mail or sent by email. 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 provide to you or the reimbursement avenues associated with your care.

Harbour Healthcare often may provide chiropractic care in an “open-door” adjusting environment. An “open-door” approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open door” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Harbour Healthcare or on your relationship with our staff. 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:

Harbour Healthcare, Inc.

719 High Street, Suite 118

Portsmouth, VA 23704

(PHONE) 866.601.4443

(FACSIMILE) 866.596.6056

www.myharbourhealthcare.com

- *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 barriers 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, 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. Additionally, 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 health 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:
If you would like further information about our privacy policies and practices, please contact:

This notice is effective as of 9/1/05, 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.

Name (Printed)	Signature	(Date)
-------------------------	-----------	--------

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

(Personal Representative Printed)	(Personal Representative Signature)	(Date)
---	---	--------

(Description of the authority to act on behalf of the patient)