NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully and sign.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practice, legal duties, and your rights concerning your health information. I must follow the practices that are described in this Notice while it is in effect.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information I created or received before changes were made. Before making significant changes in privacy policies, I will change this notice and make it available to you upon request.

I MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR:
Treatment: I may disclose your health information to a physician or healthcare provider delivering treatment to you.

Payment: I may discuss your health information with your health insurer to verify that you are eligible for benefits if you are seeking reimbursement from your insurer

Healthcare Operations: I may disclose medical information about you for various practice functions such as reviewing the equality of care delivered, education or treatment planning.

Appointment Reminders: I may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, messages left with household members, postcards, etc.).

Business Associates: I may provide your medical information to outside parties so they can perform certain functions on my behalf (e.g., ordering herbal prescriptions).

Health Related Benefits and Services: I may use and disclose medical information to tell you about health related benefits or services that may be of interest to you.

Your Authorization: You may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

Your Family and Friends: I may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or for payment of your healthcare, but only if you agree that I may do so.

Marketing Health-Related Services: I will not use your health information for marketing purposes without your authorization.

Judicial Proceedings/Law Enforcement: I may disclose medical information about you in response to a court or administrative order, subpoena, discover request or when required to do so by law.

Abuse or Neglect: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health of others.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. You must make the request in writing to obtain access to your health information.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information I use or disclose about you for treatment, payment or health care operations. You also have the right to request I limit the medical information I disclose about you to someone who is involved in your care, such as family member or friend. I am not required to agree to these restrictions, but if I do, I will abide by our agreement, except in an emergency. You must make your request to me in writing.

Right to Request Confidential Communication: You have the right to request that I communicate you about your medical matters in a certain way or at a certain location. For example, you may ask that I only contact you at work or by e-mail. Your request must provide satisfactory explanation regarding how payments will be handled under the alternative means or location of your request. You must make your request to me in writing.

Complaints: If you believe that your privacy rights have been violated you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice or the Secretary, please contact the Privacy Officer at: (215) 242 6663. You will not be penalized for filing a complaint.

ACKNOWLEGEMENT OF PRIVACY PRACTICES

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

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Signature of patient or representative Date

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Print patient name Patient Birth Date

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Craig Cernosek, D.C. Date