Notice of Privacy Practices

Effective February 23, 2003

THIS NOTICE DESCRIBES HOW THE CHIROPRACTIC DOCUMENTATION (MEDICAL RECORDS) AND OTHER PERSONAL HEALTH INFORMATION OBTAINED IN THIS OFFICE ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This chiropractic office, Barneveld Family Chiropractic, LLC, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. **The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to you PHI. The Practice is also required by law to abide by the terms of this Notice.**

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment- I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me by Dr. Kimberly Horsfall, D.C. and/or other licensed Doctor of Chiropractic who, now or in the future, work at Barneveld Family Chiropractic, LLC.

I have had the opportunity to discuss with Dr. Kimberly Horsfall, D.C and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

We may use your PHI to provide you with treatment. We may disclose your PHI to chiropractic physicians, chiropractic technicians, chiropractic assistants, medical physicians, nurses, medical technicians, clinicians, chiropractic or medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process, share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

For Health Care Operations- We may use and disclose your PHI for our own health care compliance operations and the operations of other individuals or organizations involved in providing your care. This is

necessary for us to operate with all necessary rules and regulations to be compliant and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

BILLING AUTHORIZATION & RELEASE

We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services. The office has the right to choose to send it into health insurance.

I understand and agree all of the services or charges rendered to me are ultimately my responsibility and due at the time of service which includes copays, coinsurance, and deductible. Furthermore, any service or charges not covered by insurance are required to be paid in full at the time of the service or upon insurance denial. Non-insured patients will be charged a $3.50 monthly statement fee in the event that there is a balance due on their account at the end of the month and a statement needs to be sent. I further agree that the authorization and release is irrevocable and ongoing until all monies owed are paid in full.

I authorize the release of any medical or other information necessary to process any claim for reimbursement for services incurred. I also authorize the direct payment of any medical benefits from an insurance company or other health benefit plan to Barneveld Family Chiropractic, LLC on my behalf.

I understand that out standing accounts with balance due will receive three (3) monthly statements, then a right to cure statement, and then will be sent to collections. In addition, you will be charged 1.5% interest per month with a 12% total annual interest rate until balance is paid in full.

In the event of a returned check, a charge of $30 will be applied to your account. I agree to be responsible for legal fees, collection fees, and any other expenses incurred in collecting the Clinic's account.

I also understand that if I am not able to cancel a previously scheduled appointment within 4 hours of the scheduled time or do not show up for said appointment, that Barneveld Family Chiropractic, LLC will assess a $10 charge to my account.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. I agree to keep the balance that I owe the Clinic at no more than $350, unless we agree in writing to a higher balance. If I do not have insurance, I agree to pay all amounts owed at the time of a service is rendered or at the end of each week. If I am an insurance assignment patient, I agree to pay my deductible in full and/or pay my co-insurance at the time a service is rendered or at the end of each week.

We are committed to great service… and expect to be fairly paid for it. We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient.

OTHER USE & DISCLOSURES THAT ARE

REQUIRED OR PERMITTED BY LAW

There are other uses of PHI where the Practice may also use and/ or disclose your PHI without your consent or authorization in the following instances:

Personal:

Personal Representative- The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Appointment Reminders- We may use and disclose your PHI to remind you by telephone, email, text, or mail about appointments you have with us, wellness visits, or exams, or to follow up on missed or cancelled appointments. I agree that you may contact me with appointment reminders, information about treatment alternatives, or with other health related information that may be of interest to me by phone, and may leave messages on my answering machine or with the individuals at my home or place of employment.

Periodically, we produce newsletters, offer special promotions and develop special events for educational purposes. In addition, we may send you a thank you for your patient referral, a birthday card, celebration of a birth or special accomplishment. Some or all of these occasions may also be posted on our bulletin board accompanied by a picture.

Individuals Involved in Your Care or Payment for Your Care- Certain limited PHI that is directly related to that person's involvement with your care or payment for your care may be disclosed to a family member, other relative, a close friend, or any other person identified by you. We may use or disclose your PHI to notify those persons of your location or general condition or if an emergency situation should occur. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others about your PHI.

I consent to your disclosure of my medical records to the following persons, including those who are involved in my care or payment for that care (circle those that apply):

My spouse Any member of my immediate family Other: _____

This consent is in effect until revoked by you. You may revoke this consent at any time by giving a written notice of revocation to us. Revocation of this consent will not affect any action we took in reliance on this

To Avert Serious Threat to Health or Safety- We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Emergency Situations- The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Business Associate:

Business Associate- The Practice contracts with several Business Associates and may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Government Agency related:

Public Health and Safety Activities- The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls on products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence- We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities- We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings- We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes- We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or person who committed a crime in emergency circumstances

Coroners, Medical Examiners and Funeral Directors- We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation- To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation- We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions- If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research- We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that identifies who you are, we will ask for your permission.

Fundraising- We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

Disaster Relief- In the event a disaster occurs, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information- Where appropriate, the Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes- We will not use or disclose your PHI for marketing purposes such as testimonials for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information- We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have rights to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization- You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions- You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restrictions. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications- You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy- You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete and Authorization to Release/Obtain Information from or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. **You may be charged a fee for the cost of copying, mailing or other expenses related with your request.**

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend- If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted, the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures- You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before February 23, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or charge your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice- You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive the Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint- You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

Marketing Purposes- We will not use of disclose your PHI for marketing purposes such as testimonials for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Dr. Kimberly Horsfall, D.C.

Address: 101 S. Jones Street, Barneveld, WI 53057

Telephone No.: 608-924-2424

This authorization and release will be in continual effect until revoked by both parties.

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge I was offered a copy of this Notice, and my understanding and my agreement to its terms.

I acknowledge I was offered a copy of the Consent for Use or Disclosure of Health Information/Notice of Privacy Practices, Marketing Authority, Billing Authorization & Release, and Informed Consent to Treat, and I understand and agree to its terms. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

We encourage your feedback and we will not retaliate against you in any way for the filling of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, any information we create or receive in the future. We will add any revised terms to our website for patient access.

_____

Print Patient Name

_____ _____

Signature of Patient or Personal Representative **Effective Date**

Consent for Treatment of Minor (If applicable)

I, being the parent, guardian or custodian of _____, a minor, the age of ____,

do hereby authorize, request and direct Dr. Kimberly Horsfall to perform, in her judgement, and necessary

examination, X-ray, and chiropractic treatment for the condition.

_____

Print Parent or Guardian name

I acknowledge receipt of a copy of Notice of Privacy Practices, and my understanding and my agreement to its terms.

Barneveld Family Chiropractic, LLC
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Barneveld, WI 53507
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