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.

CONFIDENTIAL

Don L. Klinginsmith, D.C. Bonnie L. Klinginsmith, D.C. Merri A. Meyers, D.C.
Elizabeth L. Hagan, D.C Parker W. Klinginsmith, D.C.

In the course of your care as a patient at our chiropractic office, we may use or disclose personal and health related information about you in the following ways:
*Your personal health information, including 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, to provide information about alternatives to your present care, or to other health related information that may be of interest to you. If you are not at home/work to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain 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 you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- 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 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 described in the examples outlined above, will only be made upon your written authorization.

*We normally provide information about your health care 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 a right to get a copy of your paper or electronic medical record, to correct your paper or electronic medical record, to request confidential communication, to ask us to limit the information we share, to get a list of those with whom we've shared your information, to get a copy of this privacy notice, to choose someone to act for you, and to file a complaint if you believe your privacy rights have been violated.

________________________________ ________________
Signature Date

By signing above I acknowledge I have read the above information and give full disclosure of my information.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED____________________________ DATE__________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of the medical benefits to the undersigned physician or supplier for services described below.

SIGNED____________________________