Woon's Healing Arts Center

253-272-9959
115 S. 8th Street Tacoma, WA 98402

Cancellation Policy

If you must cancel or reschedule your appointment,

a **24-hour notice** is required.

You will be charged for all missed appointments.

_____

Initial and date

Dr. Cathryn Woon
Woon's Healing Arts Center
115 S. 8th Street Tacoma WA 98402
253-272-9959

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the bodies corrections of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the bodies innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a heath care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the bodies innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the
(Print name)
above statement.

All questions regarding the doctor's objective pertaining to my care in the office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN BET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes and treatment, payment, and health care operations.

> **Treatment** means providing, coordinating, or managing health care and related services by one or more health care provider. For example, we may need to share information with other health care providers, or specialists involved in the continuation of your care.
> **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing to collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
> **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the even of an emergency or your incapacity, we will use our professional judgement in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial, or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We ma deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effected for all protected health information that we maintain. Revisions of our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Woon's Healing Arts
115 S. 8th Street
Tacoma, WA 98402
Phone 253-272-9959 Fax 253-272-5595

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

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115 S. 8th Street
Tacoma, WA 98402
253-272-9959

Christopher Woon L.A.C **Cathryn Woon D.C**

Notice of privacy practices Receipt and Acknowledgement of Notice

Patient/Client Name:

_____

Date of birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Woon's Healing Arts Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Woon's Healing Arts at the above address.

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian, or Personal Representative **Date**

_____

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

☐ **Patient/Client refuses to acknowledge receipt:**

_____

Signature of Staff Member **Date**