***Shakley Chiropractic***

***Bayshore Medical Group***

185 Harry S. Truman Pkwy. Suite 100, Annapolis, Maryland 21401

P: 410-263-4171 / F: 410-263-4275 / E: shakleychiropractic@gmail.com

Ryan D. Shakley, D.C.

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED

AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY:

This Practice is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or briefcase and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice’s office. It may be necessary to take patient files to a facility where a patient is confined or to a patient’s home where the patient is to be examined or treated.

NO CONSENT REQUIRED:

The Practice may use and/or disclose you PHI for the purposes of:

1. Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice’s staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this Office.
2. Payment – In order to get paid for services provided by you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
3. Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice’s personnel in providing care to you.
4. The Practice may use and/or disclose your PHI without a written Consent from you, in the following additional instances:
	1. De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.
	2. Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate will appropriately safeguard your PHI. A business associate is the 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 or other payers.
	3. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
	4. Emergency Situations –
		1. For the purpose of obtaining or rendering emergency treatment to your provided that the Practice attempts to obtain your Consent as soon as possible; or
		2. 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.
	5. Communication barriers – If due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgement, that your Consent to receive treatment is clearly inferred from the circumstances.
	6. Public Health Activities – Such activities include, for example, information collected by a public health care authority, as authorized by law, to prevent or control disease and that does not identify you, and even without your name, cannot be used to identify you.
	7. Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
	8. Health Oversight Activities – Such activities which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions or general oversight activities relating to the community’s health care system.
	9. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
	10. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purposes of identifying you or determining your cause of death.
	11. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity of whom you have agreed to donate your organs.
	12. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
	13. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to lessen a serious imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
	14. Workers’ Compensation – If you are involved in a Worker’s Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers’ Compensation system.

APPOINTMENT REMINDER:

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice; a) postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

*Please turn over to other side*

SIGN-IN LOG:

The Practice maintains a sign-in log for individuals seeking care and treatment in this Office. The sign-in log is located in a position where staff can readily see who is seeking care in the Office, as well as the individual’s location within the Practice’s office suite. This information may be seen by and is accessible to others who are seeking care in the Practice’s office.

1. If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonable infer from the circumstances based on the exercise of its professional judgement, that you do not object to the use or disclosure.
2. If you are not present, the Practice will, in the exercise of professional judgement, determine whether the use or disclosure is in the best interests and, if so, disclose only the PHI that is directly relevant to the person’s involvement with your care.

AUTHORIZATION:

Uses and/or disclosures, other than those described above, will be made only with your written authorization.

YOUR RIGHTS:

1. You have the right to:
	1. Revoke any Authorization and/or Consent, in writing, at any time and to request a revocation, you must submit a written request to the Practice’s COMPLIANCE OFFICER.
	2. Request restrictions on certain use and/or disclosure of your PHI as provided by law; however, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice’s COMPLIANCE OFFICER. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice’s use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your requests, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
	3. Receive confidential communications or PHI by alternative means or at alternative locations; you must make your request in writing to the Practice’s COMPLIANCE OFFICER. The Practice will accommodate all reasonable requests.
	4. Inspect and obtain a copy of your PHI as provided by law. To inspect and copy your PHI, you are requested to submit a written request to the Practice’s COMPLIANCE OFFICER. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
	5. Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice’s COMPLIANCE OFFICER. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice, if the information is not part of the information you would be permitted to inspect and copy and/or if the information is accurate and complete. If you disagree with the Practice’s denial, you will have the right to submit a written statement of disagreement.
	6. Receive an accounting of disclosures of your PHI as provided by law. The request should indicate in what form you want the list (such as a paper or electronic copy).
	7. Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice’s COMPLIANCE OFFICER.
	8. Complain to the Practice or to the Office of Civil Rights. U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, D.C., 20201. 202-619-0257. To file a complaint with the Practice, you must contact the Practice’s COMPLIANCE OFFICER. All complaints must be in writing.
	9. To obtain more information on, or have your questions about your rights answered, you may contact the Practice’s COMPLIANCE OFFICER, Ryan D. Shakley, 410-263-4171 or via email at shakleychiropractic@gmail.com.

PRACTICE REQUIREMENTS:

1. The Practice:
	1. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice’s legal duties and privacy practices with respect to your PHI.
	2. Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following statutes: Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted disease and Section 456.057 relating to patient records ownership, control and disclosure.
	3. Is required to abide by the terms of this Privacy Notice.
	4. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
	5. Will distribute any revised Privacy Notice to you prior to implementation.
	6. Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS:

 You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below who is the COMPLIANCE OFFICER and Contact Person appointed for this Practice. The COMPLIANCE OFFICER is Ryan D. Shakley. You may file a complaint with the COMPLIANCE OFFICER if you believe that your privacy rights have been violated relating to release of your protected health information. You may also submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the COMPLIANCE OFFICER. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE:

This Notice is in effect as of \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand this form will be placed in my patient chart and maintained for six years.

\*Patients who refer to our office are listed on “Our Honor Roll” Referral Board. If you would not like your name listed on this board, please inform the Office immediately. Thank you.

Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Custodial Parent or Legal Guardian (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_