

DR. DON LOUNSBURY

2600B LEBANON ROAD  
NASHVILLE, TN 37214  
615-883-9000

**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.**

In the course of your care as a patient at Dr. Lounsbury's Office, we may use or disclose personal and health related information about you in the following ways:

*\*Your protected health information (PHI), 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 PHI may be used to obtain information needed to treat you. For example, we may ask for results of tests or other medical records from other healthcare professionals. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.*

*\*Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you received from Dr. Lounsbury. For example, we may contact your health insurer to certify that you are eligible. We may also use and disclose your PHI to collect or help collect payment for services, such as, but not limited to, insurance carriers, guarantors, and collection agencies.*

*\*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 services provided to you.*

*\*Your name, address, phone number, email, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.*

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, email address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*\*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 that 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 outlined in this notice, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to

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whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health 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 specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by

the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our policy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

**Tricia Taylor**

If you would like further information about our privacy policies and practices please contact:

**Tricia Taylor**

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

You have a right to receive an accounting of any such disclosures made by this office.

**Acknowledgement of Receipt of HIPAA Notice of Privacy Practices for Dr. Don Lounsbury**

**Federal law requires that we obtain your written acknowledgement of receipt of Dr. Lounsbury's Notice of Privacy Practices**

Please sign or initial below.

I acknowledge that I have received Notice of Privacy Practices for Dr. Lounsbury.

Patient Name (Print): \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Legal Representative Name (Print) (if patient unable to sign): \_\_\_\_\_

Patient or Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Use or Disclose Protected Health Information**

Your authorization is requested for purposes of delivering your care in an open-adjusting or open-door adjusting environment as described in the office's privacy notice.

In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing.

If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

Name: \_\_\_\_\_

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

If you are a minor or if you are being represented by another party please provide the appropriate person's:

Name: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to the patient: \_\_\_\_\_

This authorization expires on: \_\_\_\_\_