THE OFFICE OF DR. STEPHEN M. WRINN, DC
PRIVACY STATEMENT ACKNOWLEDGEMENT

At The Office of Dr. Stephen M. Wrinn, Chiropractor, maintaining our patients trust and confidence is very important to us. That is why we have made it our priority to keep the information you provide us safe and confidential. Our employees are educated on the importance of maintaining the confidentiality of your health information. We are required to follow the privacy practices described below while this Notice is in effect. This notice is effective March 7, 2006, and will remain in effect until we replace it.

The Practice's Privacy Notice has been provided to me prior to my signing this form. The Privacy Notice includes a complete description of the uses and /or disclosures of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out healthcare operations. The practice explained to me that the Privacy Notice is available to me now, or in the future at my request.

CHANGES TO NOTICE:

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. Any changes we make to our privacy practices and /or this Notice may be applicable to health information created or received by us prior to the date of the change. For more information about our privacy practices or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

I understand that, and consent to, the following; 1) appointment reminders that may be used by the Practice: a) a postcard mailed to me at the address provided to me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, as well as a secure voicemail at work, 2) birthday postcards which may be sent periodically to patients of the Practice, 3) We are a referral office and like to thank those who refer. We will send a thank you card to a person who referred with the first name of the patient who was referred. We also have a thank you board in the office that displays the first initial and last name of the referring person.

The practice may use and /or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

I understand that I may specifically authorize The Practice to use my health information for any purpose or to disclose my health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from me in writing The Practice can then use or disclose my health information in accordance with that authorization while it was in effect. Unless I give The Practice a written authorization, The Practice cannot use or disclose my health information for any reason except those permitted by this Notice.

I understand that I have a right to request an accounting of the disclosure of my PHI other then for treatment, payment and /or health care operations. I understand I may restrict access or discloser of my PHI. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction, is binding on the Practice.

I understand that the Practice may share my PHI with the Connecticut Chiropractic Association in the event advocacy is needed for insurance claims or utilization disputes.

I acknowledge that I have received the Privacy Statement of the office of Dr. Stephen M. Wrinn.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual
______________________________	______________________________
Signature of Legal Representative	Relationship
Date Signed___/___/_________	Witness:______________________

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office of Dr. Stephen M. Wrinn will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the office of Dr.Stepehn Wrinn will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In addition, if my account becomes delinquent by more than 60 days from the due date, I hereby agree to pay any and all costs of collection, including a reasonable attorney's fee.

Signature Physician:______________________________ Signature Patient:______________________________

I hereby authorize and release Dr. Stephen M. Wrinn and whom ever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies , workers compensation carriers, welfare funds, or the patient's employer. I understand in some instances, and in accordance with applicable law, The Practice may be required to disclose my health information to appropriate authorities if The Practice reasonably believes that I am a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

I understand that only as permitted by law, The Practice may disclose my health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

I understand that under certain circumstances The Practice may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances I am aware that The Practice may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of these individuals. The Practice may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities.

I understand that The Practice will not use my health information for marketing communications without my written authorization.

PATIENT RIGHTS:

I understand that upon written submission of a written request to The Practice, I have the right to review copies of my health information, with limited exceptions. I may obtain a form to request access by using the contact information listed at the end of this Notice. I may request that The Practice provide copies in a format other than photocopies and that The Practice supplies records in that format if it is readily available. If I request copies, The Practice will charge me $0.45 per page and the reasonable cost of labor involved in making the copies (not to include record handling or retrieval fees). If I request that the records be mailed, The Practice may charge me for postage. Additionally, The Practice may charge me the amount necessary to cover the costs of materials for furnishing copies of x-rays. The Practice will not charge me for records used to support a claim or appeal under the Social Security Act.

If I request records in an additional format, The Practice may charge a reasonable cost-based fee for providing my health information in that format. If I prefer, The Practice will prepare a summary or an explanation of my health information for a fee. I can contact The Practice using the information listed at the end of this Notice if I am interested in receiving a summary of my information instead of copies.

Upon written request, I have the right to receive a list of instances in which The Practice disclosed my health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by me, for the last 6 years, but if I request this accounting more than once in a 12 month period, The Practice may charge me a reasonable, cost-based fee for responding to these additional requests.

I have the right to request that The Practice places additional restrictions on their use or disclosure of my health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of my request, The Practice may, or may not agree to those restrictions. If The Practice does agree to my requested restrictions, The Practice must abide by those restrictions, except in emergency treatment scenarios. I have the right to request that The Practice communicates with me about my health information by alternative means or to alternative locations (e.g., at my place of business rather than my home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location I have requested.

I have the right to request that The Practice amends my health information. I understand that such requests must be made in writing, and must explain why the information should be amended. The Practice may deny my request under certain circumstances.

Patient Full Name (Please Print):________________________ Signature Patient: ________________________________

Parent or Guardians Signature: ______________________________

QUESTIONS AND COMPLALINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints:

Stephen M. Wrinn, DC
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