Rejuvenations Inc / Dr. Repice

NOTICE OF PRIVACY PRACTICES

HIPAA Privacy Authorization Form
****Authorization for Use or Discolsure or Protected Health Information**
(Required by the Health Insurance Portability & Accountability Act, 45 C.F.R. Parts 160 and 164)**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Uses and disclosures- Please read this in its entirety and carefully.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Payment is collected prior or at the time the Consultation / Coaching Call is initiated . We accept all major Credit Cards

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of this practice; **REJUVENATIONS INC & DR REPICE.**
For example, information on the service you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits an inspections to facilitate law enforcement investigations and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

Other uses and disclosures: Disclosure of you health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Additional uses of information:

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send your information describing other health-related goods and service that we believe may interest or be of benefit to you.

Individual Rights: You have certain rights under the federal privacy standards. These include:
* The right to request restrictions on the use and disclosure of your protected health information.
* The right to receive confidential communication concerning your medical conditions and treatment.
* The right to inspect and copy your protected health information.
* The right to amend or submit corrections of your protected health information.
* The right to receive an accounting of how and to whom your protected health information has been disclosed.
* The right to receive a printed copy of this notice.

The duties of this medical practice known as **REJUVENATIONS INC / DR REPICE.**
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulation. Whatever the reason for the revision, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to inspect information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access by asking our receptionist or contacting the Privacy Officer in writing.

Complaints: If you would like to submit a comment or complaint about our privacy practices, or suspect violation, you do so by letter, outlining your concerns. Please address this correspondence to The Privacy Officer care of this medical practice at our current address.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as **REJUVENATIONS – Chiropractic Care Center** or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure you should make the request in writing.

This practice however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____
Name of Patient (Please Print Clearly)

_____ _____
Signature of Patient **Date**

Rejuvenations Inc - TeleHealth Coaching

INFORMED CONSENT

Informed Consent to Telehealth: To better serve the needs of patients, our services may be available by telehealth (two-way interactive video communication and electronic transmission).

This consent explains telehealth care. If you have any questions, please ask your provider. I understand that I may be evaluated and treated via telehealth and agree to the following:

1. Telehealth Services: Telehealth involves transmission of video or digital photographs of me, and/or details of my health ("Transmitted Data"). All Transmitted Data is sent via electronic means to my provider(s) to facilitate health care services. I understand that: a) Telehealth is different from traditional care in that the patient and provider do not meet physically in-person; b) Patients will be informed of any additional personnel that are to be present, seen or unseen, during the encounter. Patients must inform their Provider of any person other than the patient who is present. Patients have the right to exclude anyone from either location;
c) Patients have the right to refuse or stop participation in telehealth services at any time and request an in-person appointment, however, equivalent in-person services might not be available at the same location or time as telehealth services. A refusal to participate in telehealth will not affect rights to future care or benefits to which a patient may otherwise be entitled; d) Patients have the right to follow-up with their provider as necessary with questions or concerns; e) Benefits of telehealth include that the patients and providers can continue health care services when an in-person appointment is not possible or is inconvenient. The provider can also visualize some of the client's environment. Telehealth may also minimize exposure to illness;
f) There are also risks involved in telehealth including, without limit, losing the ability to; a) perform aspects of a physical examination (for example listening to the patient's heart and lungs or verifying vital signs); b) read physical or vocal cues/tones, and facial expressions; and c) provide immediate emergency physical services/care; g) Additionally, technical issues may disrupt the visit. There are also risks to preserving confidentiality including the risk that communications may be overheard; and that communications may be accessed by unknown third-parties; 8) Patients shall have to access to all medical information resulting from the telehealth services as provided by applicable law for patient access to medical records.

2. Confidentiality: All confidentiality protections required by law or regulation will apply to my care. Although confidentiality extends to communications by text, email, telephone, videoconference and other electronic means, providers cannot guarantee that those communications will be kept confidential and/or that a third-party may not gain access to such communications. With electronic communication, there is always a risk that communications may be compromised, unsecured, and/or accessed by a third-party. To help maintain confidentiality when engaging in electronic health services, it is important that all sessions be conducted in a confidential place. This means that clients agree to participate in telehealth only while in a room or area where other people are not present and cannot overhear the conversation. Do not have sessions in public places. Sessions may not be recorded and patients must seek written permission before recording any portion of the session and/or posting any portion of sessions.3.Emergencies:Telehealth is not appropriate if I am experiencing an emergent health care situation. If am experiencing an emergency, I understand that it is my responsibility to immediately call 911. If an emergency develops during telehealth services, I understand that it is my responsibility to immediately inform my telehealth provider, call 911 and stay connected with my telehealth provider (if possible) until help arrives.

I have read and agree to the terms in the Telehealth Consent.

I understand that telehealth is not a substitute for in person health care services.

I understand that telehealth is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact 911.

Print Name: _____

Signature: _____ Date: _____