Summary of HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

***A full version of this Privacy Notice is available to you at the front desk**

Under the Health Insurance Portability and Accountability Act of 1996("HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new provisions effective for all protected health information that we may maintain. In the event that we make a material revision to the terms of our notice, a revised notice will be made available to you within 60 days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (817)- 518-1112.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written consent or authorization, and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment or services.

Payment: We may use or disclose your health information for services you receive at our office, paid for by your insurance carrier.

Health care Operations: We may use or disclose your health information for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, underwriting, premium rating, management, and general administration activities.

Business Associates: There may be instances where services are provided to our office through contracts with a third party "business associates". Whenever a business associate involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by federal, local, or state law.

Communication with Family or Friends: Our professionals, using their best judgement, may disclose to a family member, other relative, close friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. The office may also disclose your conditions to friends and family members who accompany you to our office.

Coroners, Medical Examiners, and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers' Compensation: We may disclose health information to the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other programs established by law.

Research: Under certain circumstances, our office may use and disclose medical information about you for medical research purposes.

HIPAA Policy
TCR Chiropractic & Wellness
625 Parkview Dr, Ste 103
Trophy Club, TX 76262
Ph: 682.831.1951
Fax: 682-292-2946

According to the Texas States Law and per HIPAA policy, our practice is not allowed to release any of your information without your permission. Please list any individuals that you are giving permission to receive or pick up any health information. Please list any individuals that you are giving permission to receive information regarding you as a patient at our practice.

Name: _____ Date of birth: ___/___/_____
Address: _____
Phone: _____ Relationship: _____

Name: _____ Date of birth: ___/___/_____
Address: _____
Phone: _____ Relationship: _____

Name: _____ Date of birth: ___/___/_____
Address: _____
Phone: _____ Relationship: _____

Name: _____ Date of birth: ___/___/_____
Address: _____
Phone: _____ Relationship: _____

Name of Patient/Guardian: _____ Date: _____

Signature of Patient/Guardian: _____ Date: _____

Relationship to Patient if signed by someone other than patient_____ Date: _____

Consent to Treat: I consent to the administration of health care by TCR Chiropractic & Wellness. I understand that I may set conditions or limitations on my treatment and care and that if I wish to provide such conditions, I will be given the opportunity to write those in a separate document. I have been informed and acknowledge that I may withdraw my consent at any time upon written notice to TCR Chiropractic & Wellness. I am giving my consent to the administration of health care by TCR Chiropractic & Wellness voluntarily, and I hereby knowingly and voluntarily enter this Health Care Consent for Treatment. TCR Chiropractic & Wellness is a rehabilitation center only and encourages all patients to keep a Primary Care Physician.

Agreement for Benefit Assignment and Financial Responsibility: I agree to pay for all services rendered to me by a TCR Chiropractic & Wellness physician and/or other qualified healthcare provider employed by TCR Chiropractic & Wellness I agree that I am responsible to provide timely information about my insurance coverage and changes in coverage as they occur. I agree to respond promptly to requests for information from my insurance company as they occur. I assign TCR Chiropractic & Wellness benefits due to me or become due to me because of the medical services I receive from TCR Chiropractic & Wellness physician or other qualified healthcare provider. I further authorize the payments to be paid directly to TCR Chiropractic & Wellness. I also understand that I am responsible to TCR Chiropractic & Wellness for any payments made directly to me for services TCR Chiropractic & Wellness provided to me. If this account is not paid in accordance with TCR Chiropractic & Wellness policies, I agree and guarantee to pay collection costs, including reasonable attorney fees, collection agency fees, and interest from the date of demand.

If Medicare, Medicaid, Workers' Compensation, or other similar government programs should determine that I am not eligible for coverage or that the treatment is not covered, I will be responsible for payment, unless prohibited by law.

If no insurance, third-party insurance, or motor vehicle accidents you will be responsible for all charges associated with your care. Any balance on your account is your responsibility to pay in full at the end of the office visit. Likewise, any associated medical procedure will require a prepayment of 50% of the physician's fee and the balance will be billed to the patient. We do not file insurance to third-parties or insurance carriers and do not accept liens. You will be responsible for all charges as well as billing appropriate carriers as you like. For patients without insurance, we do offer a cash discount to patients who pay in full at the time of service. We can arrange payment plans upon request. There are no discounts for third-party carriers.

Acknowledgement of Privacy Polices/HIPAA: I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time, and I have the right to request new copies at any TCR Chiropractic & Wellness location during regular business hours.

☐ Accepted

☐ Declined

_____ Patient's Initials

By my signature below, I am acknowledging receipt of this document and agree to the terms under all five actions of this document. Agreement Consent to Treat, Benefit Assignment and Financial Responsibility and receipt of Privacy Policies/HIPAA.

Name of Patient/Guardian: _____ Date: _____

Signature of Patient/Guardian: _____ Date: _____

Relationship to Patient if signed by someone other than patient_____ Date: _____