Krantz Family Chiropractic & Wellness Center
Dr. Michael Krantz
3882 Skippack Pike - Skippack, PA 19474
(610) 222-9555 Voice **(610) 222-9556 Fax**
Dr_Mike@Comcast.Net **www.DrMikeKrantz.Com**

Notice of Privacy Practices – SHORT FORM

This is the **short form** that is *required by the federal government* for ALL physicians and healthcare providers as of April 14th 2003. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You may request at any time to read the more detailed LONG form version of our office's privacy policy. This requirement is detailed in the HIPAA (Health Insurance Portability and Accountability Act), for more information on HIPAA you can visit the official website at http://www.cms.hhs.gov/hipaa/ If you have any questions about this Notice please contact our Privacy Contacts who are Linda, Joanne or Dr. Michael Krantz.

HIPPA Consent Short Form as per Federal HIPAA Law #101-191
Please review the following information in its entirety, and sign at the bottom.

- Trust is the foundation of the doctor/patient relationship
- The information you provide us is kept in the strictest of confidence.
- While protecting your privacy is extremely important to us, there may be certain instances in which we may have to disclose your private health care information**:** (*See long form for details*)

1.) To use or disclose to ***another healthcare provider*** or hospital as necessary for proper referral, diagnosis, assessment, treatment, emergency room visits, etc.
2.) To use for ***billing*** to a third party insurer, worker's compensation insurance, personal injury insurance (auto, etc.), or in the use of insurance review such as with a URO, PRO, IRO (Utilization, Peer and Independent Review Organization), or IME (Independent Medical Examiner).
3.) To use for ***internal practice*** and quality controls, or to ensure proper treatment by directed staff members such as physical and massage/soft tissue therapists
4.) To ***your*** personal legal counsel, ***with written consent only***, in the case of litigation from a worker's compensation or personal injury claim.

Patient Rights under HIPAA LAW #101-191:
You have the right to request that we not disclose your private information to specific persons, companies, or organizations except where we are required to by state or federal law, or subpoena. You must submit this request signed, and dated in ***writing***. We have the right to refuse the request if our office feels that there is a significant health risk, at our discretion, to you by ***not*** disclosing the information. You have the right to revoke your Authorization signed and dated in ***writing***. ALL request will be honored as of the ***following business day*** from the date signed (to allow proper processing time internally), we cann ot be held accountable for anything sent out on the day the request is received. Please note that even if you wish to restrict total access on your file, or from a particular company or agency, our office may be ***directed by law*** to release this information as part of a request by your insurance carrier. By denying access of your medical records to your insurance carrier, you take **FULL** responsibility to pay all claims should they deny payment based on lack of medical documentation.

I acknowledge that once I sign this consent form, that I will agree to the terms and conditions as set down by Federal HIPAA Law. Should you wish to read the ***LONG*** form of our office privacy policies please make this request before signing this form. Please see a member of our privacy team if you have any questions or need assistance in completing this form.

Printed Patient name: ____________________ Signed: _________________ Date: ___/___/_____

Printed Witness name: ____________________ Signed: _________________ Date: ___/___/_____

This notice was published and becomes effective on April 14, 2003, as per HIPAA Guidelines.

(Turn Page Over)

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Office Procedures – SHORT FORM

This is the **short form** that is *required by the federal government* for ALL physicians and healthcare providers as of April 14th 2003. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You may request at any time to read the more detailed LONG form version of our office's privacy policy. Thiss requirement is detailed in the HIPAA (Health Insurance Portability and Accountability Act), for more information on HIPAA you can visit the official website at http://www.cms.hhs.gov/hipaa/ If you have any questions about this Notice please contact our Privacy Contacts who are *Linda, Joanne or* Dr. *Michael Krantz.*

HIPPA Consent Short Form as per Federal HIPAA Law #101-191
Please review the following information in its entirety, and sign at the bottom.

- There may be times our office may need to use your private health information (PHI) to contact you either by phone, mail, email or text in regards to issues such as:
  - Appointment Reminders, Information about treatment & treatment alternatives
  - Insurance information and/or billing issues, etc.
  - Cards (such as birthday, get well, etc.), thank you notes for referrals & referral board
  - Other health information that may be of interest to you, including a health newsletter

- In our attempt to contact you we may not get your directly. This means that contact may be either through a letter, postcard, or voice mail (answering machine). Should you have a reason to exclude one of these methods, please let a member of our staff know your request. However, our office does reserve the right to contact you by any means necessary if we feel that it is a warranted medical emergency.

- Please submit any exclusion from contact to our office in writing, so we can make this request a permanent part of your health file.

- In order to achieve a more relaxed and family approach to healthcare, our office chooses to practice in an open style of treatment. In most cases exam and treatment rooms are often left open, ***except*** where modesty is appropriate. If at any time you would like to increase your privacy by being treated in a sealed room, or if there are issues you would like to discuss in a more secure and private fashion, please ask a member of our staff ***prior*** to your treatment or consultation. Additionally in order to keep a more personal atmosphere, our reception space is open air to the public. We chose not to employ a privacy shield or glass window so our patients feel more at home and have direct contact with the staff should they need it, rather than having to knock and feel intrusive. If at any time, you would wish to communicate with the staff privately, or have the staff exclusively communicate to you or about your PHI in a more secure location, please make the staff aware of this request.

I acknowledge that once I sign this consent form, that I will agree to the terms and conditions as set down by Federal HIPAA Law. Should you wish to read the ***LONG*** form of our office privacy policies please make this request before signing this form. Please see a member of our privacy team if you have any questions or need assistance in completing this form.

Printed Patient name: ____________________ Signed: _________________ Date: ___/___/_____

Printed Witness name: ____________________ Signed: _________________ Date: ___/___/_____

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