NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated, and applicable federal and state laws require us, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of April 14, 2003 and will remain in effect until we replace it.

There are a number of situations in which Atlas Chiropractic & Wellness Center, PA (DBA Atlas Chiropractic of Raleigh) may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate course of care for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. We may use or disclose your health information to provide you with appointment reminders or to check on your health status (such as voicemail messages, postcards, or letters). Please notify us if you have a separate phone number to which you would like us to use to contact you. 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 health. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advice us in writing as to your preferences. You have the right to refuse authorization for this office to contact you regarding these matters- it must be in writing. Your refusal will not affect the care provided to you or reimbursement avenues associated with your care.
Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.
Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions. Our office may utilize a front office sign-in sheet in the future. You will not be required to place any healthcare information on this sheet other than your signature. If you object to using the sign-in sheet please notify our office.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your

protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.
Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practical after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You Have Certain Rights regarding your health record information, as follows:
(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. However, there may not apply with regard to emergencies or if we are otherwise required by law to make a full disclosure without restriction.
(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law.
(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.
(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

If you have a complaint or question regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. John S. Boccella -Privacy and Security Officer

Atlas Chiropractic & Wellness Center, PA
10931-131 Strickland Road
Raleigh, NC 27615
(919) 518-1234

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice if I requested a copy.

_____	_____
Signature of Patient or Personal Representative	Printed Name of Patient
_____	_____
Date of Signing	Description of Personal Representative's Authority

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Atlas Chiropractic & Wellness Center, PA (DBA Atlas Chiropractic of Raleigh) or for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Atlas Chiropractic & Wellness Center, PA. I understand that analysis, diagnosis or treatment of me by Atlas Chiropractic & Wellness Center, PA may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Atlas Chiropractic & Wellness Center, PA is not required to agree to the restrictions that I may request. However, if Atlas Chiropractic & Wellness Center, PA agrees to a restriction that I request, the restriction is binding on Atlas Chiropractic & Wellness Center, PA. I have the right to revoke this consent, in writing, at any time, except to the extent that Atlas Chiropractic & Wellness Center, PA has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

At my request, I have been provided with a copy of the Notice of Privacy Practices for Atlas Chiropractic & Wellness Center, PA and I understood this document prior to signing. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Atlas Chiropractic & Wellness Center, PA. The Notice of Privacy Practices is available at the front desk of Atlas Chiropractic & Wellness Center, PA, located at 10931-131 Strickland Road, Raleigh, NC 27615. This Notice of Privacy Practices also describes my rights and duties of Atlas Chiropractic & Wellness Center, PA with respect to my protected health information.

I also authorize Atlas Chiropractic & Wellness Center, PA to use my protected health information for purposes of newsletter mailings, correspondence by e-mail, special occasion or birthday cards, testimonials, and such marketing that does not originate from outside this office. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Atlas Chiropractic & Wellness Center, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Atlas Chiropractic & Wellness Center, PA and request a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____	_____
Signature of Patient or Personal Representative	Printed Name of Patient
_____	_____
Date of Signing	Description of Personal Representative's Authority

Assignment Of Benefits And Insurance Needs/ Release Of Information

I authorize payment from my insurance company(ies) directly to Atlas Chiropractic & Wellness Center, PA (DBA Atlas Chiropractic of Raleigh) for services rendered by this assignment of benefits. The completion of insurance forms and the assignment of benefits do not relieve the undersigned of the obligation to pay the full amount owed for such services provided by Atlas Chiropractic & Wellness Center, PA. I understand that any insurance checks received by the patient must be brought into this office for processing. I authorize Atlas Chiropractic & Wellness Center, PA to release my information necessary to file claims with my insurance company(ies) as well as any other healthcare professionals related to your case. I permit a copy of this authorization to be used in place of the original.

_____	_____	_____
Name (Please Print)	Signature	Date

Cancellation Policy

In order for Atlas Chiropractic & Wellness Center, PA (DBA Atlas Chiropractic of Raleigh) to provide the highest standards for your care and to help us assist others in a timely manner, we request that you give us the courtesy of 24-hour notice if canceling an appointment. This allows us sufficient time to schedule another person who may need care in that same time. ***I understand that if I cancel after hours on the business day before my scheduled appointment or on the same day of my scheduled appointment or I do not show up for my scheduled appointment, I will be charged $50.00 for which I understand that I am personally responsible. Signing this consent only acknowledges your receiving notice of this cancellation policy, however there is no exception or exemption to this policy.***

_____	_____	_____
Name (Please Print)	Signature	Date

Witnessed By_____