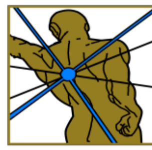


MILLENNIUM HEALTH & WELLNESS

3850 E. Lohman Ste. 100 • Las Cruces, NM 88011 • (575) 521-0793 • Fax (575) 532-1607

MILLENNIUM CHIROPRACTIC AND PHYSICAL THERAPY
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 IT CAREFULLY.

Millennium Chiropractic and Physical Therapy is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

> "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Millennium Chiropractic and Physical Therapy."
> "It is our policy to provide a substitute health care provider authorized by Millennium Chiropractic and Physical Therapy to provide assessment and/or treatment to our patients without advanced notice in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation"

Payment

We may disclose your health information to your Insurance provider for the purpose of payment or health care operations. (example)

> "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Millennium Chiropractic and Physical Therapy for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care service received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or Judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissue.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes of fundraising purposes as described below: (example)

> "As a courtesy to our patients it is our policy to call you home on the evening prior to your scheduled appointments to remind you of your appointment time. If you are not at home we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."
>
> "It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Millennium Chiropractic and Physical Therapy sponsored fund-raising events."

Change of Ownership
In the event that Millennium Chiropractic and Physical Therapy is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

** You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however, that Millennium Chiropractic and Physical Therapy is not required to agree to the restriction that you requested.

** You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

** You have the right to inspect and copy your health information.

** You have a right to request that Millennium Chiropractic and Physical Therapy amend your protected health information. Please be advised, however, that Millennium Chiropractic and Physical Therapy is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

** You have a right to receive an accounting of disclosures of your protected health information made by Millennium Chiropractic and Physical Therapy.

** You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Millennium Chiropractic and Physical Therapy reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Millennium Chiropractic and Physical Therapy is required by law to comply with this Notice.

Millennium Chiropractic and Physical Therapy is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact Sheila Burrell by calling this office at 575-521-0793. If Sheila Burrell is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how Millennium Chiropractic and Physical Therapy has handled your health information should be directed to: Sheila Burrell by calling this office at 575-521-0793. If Sheila Burrell is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ___/___/___

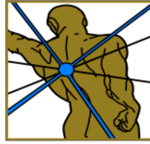
I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Millennium Chiropractic and Physical Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (print, please)

____
Patient's Signature Date

____
Authorized Facility Signature Date



MILLENNIUM
HEALTH & WELLNESS

3850 E. Lohman Ste. 100 • Las Cruces, NM 88011 • (575) 521-0793 • Fax (575) 532-1607

OFFICE POLICIES AND PROCEDURES AGREEMENT

FINANCIAL ARRANGEMENTS AND POLICIES

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office 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 this office 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 me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for products purchased and services provided by our office. Our office is a participating provider with a number of insurance companies. For your convenience, our office will make an effort to verify your insurance benefits. However, ultimately it is the patient's responsibility to determine benefit and authorization information before services are rendered. Please note that verification of benefits is not a guarantee of benefits. Your insurance company makes the final determination of insurance benefits when they consider the claim. It is understood that despite our best efforts to provide you with a financial estimate of the cost of care, times arise where insurance companies do not reimburse what was originally quoted. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company. If a referral is required but not provided at the time of your visit, full payment is expected at the time of service. Your signature below will give power of attorney to endorse checks made out to yourself to be credited to your account.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather that pay at the time of service. This may include setting up a payment plan for those who may require extensive treatment. Payment is due within 30 days of the service rendered. Bills that are delinquent more than ninety (90) days will be transferred to an outside collection agency unless prior arrangements have been made. Patients will be responsible for collection and attorney's fees for all such disputes. If there are legitimate problems, please discuss them prior to the ninety days so we may find a workable solution.

INFORMED CONSENT TO CHIROPRACTIC/PHYSICAL THERAPY CARE

I request and consent to the performance of chiropractic/physical therapy examination, adjustment/manipulation and any and all other chiropractic/physical therapy procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible for) by any of the treating doctors of chiropractic/physical therapy on staff and/or any licensed chiropractor/therapist deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, stroke, dislocations, strains, and worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise good judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

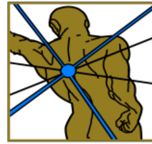
RECORDS RELEASE AUTHORIZATION & PERMISSION FOR CLINICAL RESEARCH

I hereby grant permission for Millennium Chiropractic & Physical Therapy to release any information pertaining to diagnosis and treatment to myself and care in this and other offices to my primary care physician, or to any other physician or therapist whom I am currently or previously under care with. In accordance with all stated above. I hereby understand and agree to the above stated office policies.

PRINT Patient's Name: ____

SIGNATURE of Patient or Legal Guardian: ________________________________ **Date:** _______________

Employee Initials:________________



3850 E. Lohman Ste. 100 • Las Cruces, NM 88011 • (575) 521-0793 • Fax (575) 532-1607

HIPAA RELEASE FOR TELEPHONE CORRESPONDENCE

Millennium Health & Wellness has my permission to contact me using any of the following methods:

_____May leave a message at home on answering machine

_____May leave a message at home with spouse/family member

_____May call and leave message on my cell phone _______________
cell number

_____May leave a message at work

_____

Email address: ____

I understand that Millennium Health & Wellness will be contacting me strictly for general information, scheduling or billing questions.

____ __________________

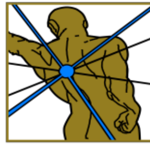
Patients Signature Date

____

Patients Name (Please Print)

Employee Initials:__________________

*If we are not able to contact you at your primary number, (i.e. number is disconnected or nonworking at the time of contact), we will attempt to contact you at any available number we have on file. We will not leave any personal information, we will only ask for a return call unless there is a medical emergency.



3850 E. Lohman Ste. 100 • Las Cruces, NM 88011 • (575) 521-0793 • Fax (575) 532-1607

POLICY ON NO SHOW/LATE APPOINTMENTS

- Due to limited space for Dr. Brian Hesser, Family Nurse Practitioner, there will be a $25 fee assessed if you fail to call and cancel your appointment 24 hours before your scheduled time so that we may be able to accommodate another patient in that appointment slot.

Please be aware that if you are late for your appointment, it is possible you will not see Dr. Hesser at your scheduled time. Patients arriving on time will be seen at their scheduled time regardless if you arrived before them.

- Due to the high demand and limited space for our massage appointments, there will be a $50 fee for 1 hour massage appointments and $25 fee for 30 minute massage appointments if you fail to call and cancel your appointment 24 hours before your scheduled time, so that we may be able to accommodate another patient in that appointment slot.

Please be aware that if you are late for your appointment your massage will not be your full time slot. We do have patients scheduled back to back and we cannot go over into their time slot if you are late.

By signing below you acknowledge that you have read and understand our policy for No Show and late Massage appointments and No Show and late Dr. Hesser Nurse Practitioner appointments.

____
Printed Patient Name

______________________________ _________________________
Patients Signature Date

______________________________ _________________________
Witness Signature Date