empowered BEST
Dr. Kathryn Lawson

Dr. Kathryn Lawson
Wholistic Chiropractor
1431 C McClendon Dr. Decatur, GA 30033
Phone: 770-939-1177 Fax: 770-939-0096

INFORMED CONSENT

A patient in coming to the Chiropractor gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment or health care if she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures what ever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The chiropractor provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Patient Signature _____ Date_____

CONSENT FOR TREATMENT

I the undersigned, a patient in this office hereby authorize Dr. Kathryn Lawson and whomever she may designate as his assistant(s) to administer treatment as is necessary. I also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and agent. 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. I permit this office to endorse remittance for the conveyance of credit to my account. However, I clearly understand and accept that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES

Purpose: This notice of Privacy Practices "Notice" presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this notice to each patient beginning no later than the date of our first service to the patient, including service delivered electronically, after April 14, 2003. We must make a good faith attempt to obtain written acknowledgment of receipt of the Notice from the patient. We must also have the Notice in our office in a clear prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice and on the website. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with above instructions. Thereafter, we must distribute the Notice to each patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Dr. Lawson is required to provide you with this Notice pursuant to the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1966 ("HIPPA") ("Privacy Rules")

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

USES AND DISCLOSURES

We may use or disclose your protected information without your written consent, written authorization or oral agreement for the following purposes:

Treatment: Example: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment: Example: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations: Example: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you while you are an inmate.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.

If there are substantial barriers to communication and we determine in the exercise of our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required by law to disclose your health information to the Food and Drug Administration.

If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose your health information to a law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner or funeral director.

For Research Purposes.

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illness.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

YOUR RIGHTS

RIGHT TO REQUEST RESTRICTIONS. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS. You have right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

RIGHT TO INSPECT AND/OR COPY. You have the right to inspect and/or copy certain health information for as long that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

RIGHT TO AMEND. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the request amend.

RIGHT TO RECEIVE AN ACCOUNTING. You have the right to receive and accounting of our disclosures of your health information made 6 years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to out Privacy Official.

The accounting will not include the following disclosures:

- Disclosures made to carry out treatment, payment and healthcare operations;
- Disclosures made to you;
- Disclosures made in our facility directory;
- Disclosures made to individuals involved with your care;
- Disclosures made for national security or intelligence purposes;
- Disclosures made to correctional institutions or law enforcement officials; and
- Disclosures made prior to the compliance date of the HIPPA Privacy Rule.

RIGHT TO RECEIVE NOTICE. Your have the right to receive a paper copy of this notice, upon request.

OUR DUTIES

We are required by law to maintain the privacy of protected health information and to provide you with notice of legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice upon request.

COMPLAINTS

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

HOW TO CONTACT US

If you would like further information about our privacy practices, please contact:

Dr. Kathryn Lawson
1431 C McClendon Dr.
Decatur, GA 30033
Phone: 770-939-1177
Fax: 770-939-0096

Effective Date: MARCH 14th, 2015

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have received a copy of this office's Notice of of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date