NOTICE OF PRIVACY PRACTICES AND OFFICE POLICY

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you this Notice. We must follow the privacy practices as described below. This Notice will take effect on 04/14/2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

TREATMENT: We may use your health information to provide you with our professional services. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Every one of our staff is required to sign a confidentiality statement.

DISCLOSURE: We may disclose and/or share your health information with other health care professionals who provide treatment and/or service to you. These professionals will have privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

PAYMENT: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in this process of mailing statements and/or collecting unpaid balances.

EMERGENCIES: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inference of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

HEALTHCARE OPERATIONS: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or that of others.

PUBLIC HEALTH RESPONSIBILITIES: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

MARKETING AND HEALTH-RELATED SERVICES: We will not use your health information for marketing purposes unless we have your written authorization to do so.

NATIONAL SECURITY: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

ACCESS: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for who you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested will be $1.00 for each page and the staff time charge will be $50.0 per hour including the time required to location and copy your health information. If you want copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

AMENDMENT: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

NON-ROUTINE DISCLOSURES: You have the right to receive a list of non-routine disclosures we have made of your healthcare information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back six years starting on April 14, 2003. Information prior to that date would not have to be released.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we did, we will abide by our agreement (except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your healthcare information. This request must be submitted in writing.

OFFICE POLICY

Dr. Yajima and his entire staff are dedicated to providing you with the finest in chiropractic healthcare. Please take a moment to acquaint yourself with our office policies. These policies are designed to enhance your doctor/patient relationship.

APPOINTMENTS: For your convenience, patients are seen on an appointment basis. We respect that your time is valuable. Kindly give 24 hour advance notice whenever possible if you must reschedule or cancel an appointment. If you do not call to reschedule or cancel prior to your scheduled appointment, you may be billed for the scheduled treatment. Leaving a message is acceptable.

WALK-INS: We do our best to accommodate those in acute pain. However, please do not abuse this service.

LATE PATIENTS: If you come in after your appointment time, you may have to wait for an opening.

AFTER HOURS: Dr. Yajima may be available for treatment after hours with a fee of $50.00 in addition to cost of services rendered. Please leave a message at the office number as Dr. Yajima checks messages regularly. Please respect the doctor's private time and do not contact him at home unless it is an absolute emergency.

FINANCIAL ARRANGEMENTS: Payment for care is due at the time of service on a cash basis. Exceptions must be agreed upon in writing prior to treatment. Cash, checks, VISA or MasterCard are accepted.

INSURANCE: We are members of several insurance panels and may have arrangements with your carrier. Copays and deductibles are paid at the time of services after benefits are determined. Until insurance benefits are verified by our staff, you are considered a cash patient. If we are unable to obtain reliable information from your carrier, we cannot take assignment on your insurance; however we will be happy to provide itemized bills for submission to your insurance carrier. Acceptance of assignments is a courtesy representing a 60-day line of credit. You must understand and agree that health insurance policies are an agreement between the insurance carrier and yourself. You may be asked to direct insurance and financial inquiries to the billing department, not the doctor.

FORMS: Forms or paperwork requiring your chart to be pulled, records reviewed, and a doctor's signature are $20 per page. Forms or paperwork requiring review of chart, form completion, and/or narrative by the doctor are $50 for every 10 minute increase, or part thereof, involving the doctor's time.

FAMILY/GUESTS: Unless agreed upon first, it is preferable that adult patients be examined without spouse or guests in the room. It is distracting to the doctor to have more than one person answering questions during the examination. Children are allowed to accompany patients when necessary. We prefer you to provide supervision for your child.

CHILDREN AS PATIENTS: Parents are expected to accompany children during examination. No child will be treated unless established as a patient.

NEW CONDITIONS: Please call ahead if you have a new problem when you have a regular follow-up visit scheduled. Otherwise we may not have adequate time set aside for a complex visit.

PATIENT RECORDS: We must have 24 hour notice to prepare your records for release. X-rays will be released to the patient with 24 hour notice and a signed release by the patient indicating where the records are going.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

PRACTICE NAME: Yajima Chiropractic & Wellness
PRIVACY OFFICER:
TELEPHONE: (310) 626-1302
FAX: (310) 626-4380
EMAIL: drhajimeyajima@gmail.com
ADDRESS: 1110 Crenshaw Blvd | Torrance, CA 90501

_____

PATIENT'S NAME (PRINTED)

_____

PATIENT'S SIGNATURE

_____

PRIVACY OFFICER'S SIGNATURE

_____

DATE

INFORMED CONSENT TO CHIROPRACTIC CARE

Hajime Yajima, D.C.

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy by the doctor of chiropractic named above.

I will have the opportunity to discuss with the doctor the purpose and benefits of the chiropractic adjustments and other treatments. Alternatives to treatment will be reviewed.

Though chiropractic adjustments and treatments are usually beneficial and rarely cause any problems, I do understand that there are some risks to treatment. Risks include but are not limited to fractures, disc injuries, strokes, dislocations, and sprains.

I understand that chiropractic is not an exact science and therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance will be made by anyone regarding the chiropractic treatment that I can request or authorize. I confirm I have taken the opportunity to read this form and can ask questions at any time. I consent to any proposed treatment.

**** Please discuss any questions or concerns with the doctor. ****

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Witness Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

You hereby assign payment to Yajima Chiropractic & Wellness / Dr. Hajime Yajima of all benefits due under the terms of your policy. Although your insurance policy is an agreement between you and your carrier, this office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain for your treatment. We have found that in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason you must understand that you are responsible to make payment in full.

I understand that I am responsible for payment of this account and hereby assume and guarantee payment of all related expenses incurred during treatment. If my current policy prohibits direct payment to the doctor, I hereby instruct and direct _____ (insurance carrier) to make out the check to Yajima Chiropractic and Wellness and mail it to 1110 Crenshaw Blvd, Torrance, CA 90501.

I also hereby authorize Yajima Chiropractic & Wellness / Dr. Hajime Yajima to release any information pertinent to my case to my insurance company, adjuster or attorney involved in my case.

**** Please do not sign this form without reading and understanding it. ****

I confirm I have read and acknowledge understanding of the office policies of Yajima Chiropractic & Wellness.

Signature: _____ Date: _____