

HIPAA HAPPENINGS

Barnes Chiropractic Health & Fitness
13890 Braddock Road
Suite 108
Centreville, VA 20121



Patient Authorization regarding a spinal screening as a procedure preliminary to consideration of chiropractic care.

It is the practice of this office to provide complimentary spinal screenings in various settings. These settings may involve several potential patients being screened in the same general area at the same time. Persons being screened are within sight of one another and some routine details of structural/postural findings are discussed within earshot of other potential patients, staff and perhaps the general public. This environment is used for preliminary screenings and it is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. When these procedures are performed they are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in a spinal screening environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and seeking your authorization.

The use of this format is intended to make your spinal screening experience more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be screened in this environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Barnes Chiropractic Health & Fitness or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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**Patient Authorization regarding chiropractic care being provided in an
"open therapy" and "open door" environment**

It is the practice of this office to provide physical therapy procedures in an "open therapy" environment. "Open therapy" involves several patients being seen in the same therapy room at the same time. It is also the desire of this office to provide chiropractic care in an "open door" adjusting environment. An "open door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Barnes Chiropractic Health & Fitness or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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Patient Authorization for appointment reminders, scheduling related matters, chiropractic care, related health services, and/or related health products

It is our desire to for our staff to use your name, address, telephone number and/or e-mail address for the purpose of contacting you to remind you about scheduled appointments; re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information use your decision will have no adverse effect on your care from Barnes Chiropractic Health & Fitness or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (print)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.