# <u>HIPAA Notice</u>

Below is a copy of Root Healing Acupuncture and Wellness's *Notice of Privacy Practices* and other pertinent information which we are required by law to provide to you.

HIPAA (Health Insurance Portability and Accountability Act) was established by Congress to develop national safeguards to protect the confidentiality of patient medical information.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice at your visit.

Please sign the acknowledgement of receipt to indicate that you have received the notices for you and other minor family members and/or dependents who receive care from Root Healing Acupuncture and Wellness.

This notice is required by law to inform you of how your health information will be protected, how Root Healing Acupuncture and Wellness may use or disclose your health information, and about your rights regarding your health information.

Each time you visit Root Healing Acupuncture and Wellness, a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnosis, treatments, and a plan for future care. This information, referred to as your medical record, serves as a:

**Basis for planning your care and treatment*
**A data source for medical research and public health*
**Means of communication among the health professionals that contribute to your care *A source of data for planning facilities, marketing healthcare services and fundraising*
**Legal documents of the care you receive*
**Means by which you or a third-party payer (i.e. health insurance company) can verify that services you received were appropriately billed*
**A tool for education of health professionals*
**A tool with which we can assess and work to improve the care we provide*

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand how others may access and use your health information; and make more informed decisions when authorizing disclosures to others.

**Patient:** ____________________ **Signature:** _____________________ **Date:** ________
(or Patient Representative)

**Office Signature:** ___________________________________________ **Date:** ________