Dear Patient,

Thank you for choosing our office to help you to get better and to get your life back. We want to explain that under the Auto Injury Law, the insurance company will not pay our bills until you are done treating with us. Afterwards, it old take months or even years for us to get paid. For this reason, we want you to understand that we are taking your case in good faith.

Many times, the insurance company will mail the chiropractic/medical payments to you. In turn, you need to take that check and pay your doctors. If you do not pay the office, 2 things can happen:

1) We send you to small claims court. Several things can result from this:
    - The court can take your wages from your paycheck to pay Aim High chiropractic for the treatments you received.
    - A lien could be placed on your house or car, meaning that you cannot sell your house or car until Aim High Chiropractic has been paid in full.
    - The courts would order that your personal belongings be taken.
    - You could face possible jail time.
2) We send you to a collection agency. Several things can result from this:
    - Collections agents can come to your door demanding payment.
    - Your credit history will be severely damaged, which means that you cannot get credit cards or loans to buy a car or house, for school, to pay your bills, and can affect employment eligibility.

Our office will do our best to get you well, and we have faith that you will help us to get paid for our services. Again, thank you for c hosing Aim High Chiropractic.

By signing this for, I understand that any checks that are sent to me from the insurance company will be used to pay my bills here at Aim High Chiropractic. I understand that if payment is not received for my treatments and services that there could be a negative consequence as listed above.

Print Name	Signature	Date

AIM HIGH CHIROPRACTIC, PC CLINICS:

50 S Federal Blvd. Denver, CO 80219 303-922-2977	1350 Chambers Rd, Ste 103 Aurora, CO 80011 303-577-2040	2532 Sheridan Blvd. Denver, CO.80214 303-458-0294	7200 W. 44th Ave Wheat Ridge, CO. 80033 303-423-1925

www.MyDenverChiropractor.com

aimhighdenver@gmail.com

( ) CHIROPRACTIC ( ) MEDICAL ( ) REHAB ( ) MASSAGE DR / RT / MT:_____

CONFIDENTIAL PATIENT FORM

Patient #: _____

Date: _____

PATIENT INFORMATION:

Name: _____ Home Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ___ Marital Status: ____ Date of Birth: ____/____/____ Social Security Number: _____

Name of spouse or nearest relative: _____ Phone #: (____)_____

Driver's License #: _____ Other ID: _____ E-mail address:_____

Occupation: _____ Employer: _____ Work Phone: (____)_____

Work Injury? Y/ N Employer notified? Y/N Name:_____

Please check the type of care desired: ( ) Lasting Correction ( ) Temporary Relief

How did you learn of this clinic? ___Yellow page / ___Spanish Yellow Pages / ___Newspaper / ___Web

___Tele-marketing / ___Sign / ___ Insurance Company / ___ Other:_____ Referred by: _____

AUTO ACCIDENT INFORMATION:

Date of Accident _____/_____/_____ Time of Accident: _____AM / PM # of people in vehicle _____

Details of Accident: _____

_____

_____

Do you have an attorney? Y / N Name: _____ Phone: _____

On Lien: Y / N Were you the: Driver ___ Passenger ___ Pedestrian ___ Did you hit the other vehicle: Y / N

Were you struck from: Behind ___ Right Side ___ Left Side ___ Front ___ Auto Parked ___

Any tickets issued? Y / N If yes, to whom? _____

Any treatments since the accident? Y / N If yes, by whom? _____

PLEASE DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY.

INSURANCE INFORMATION

MedPay/Uninsured: _____

Claim #: _____

Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Adjuster: _____

Chiro Y / N Limit: _____

Accu: Y / N Limit: _____

ATTORNEY INFORMATION

Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Notes: _____

_____

_____

Massage: Y / N Limit: _____

Acceptance of Assignment of Benefits: Y / N

3RD PARTY INFORMATION

Insured Name: _____

Claim #: _____

Ins. Co.: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Adjuster: _____

Rehab: Y / N Limit: _____

Staff Completing Info _____ Date _____

Auto Accident Information

Date and time of accident: _____

Year and make of your vehicle: _____

Year and make of other vehicle that hit you or you hit: _____

Speed of your vehicle: _____ Speed of other vehicle: _____

Position of your vehicle: [] stopped at intersection [] stopped at traffic

[] stopped at light [] making a right turn [] making a left turn

[] parking [] proceeding along [] accelerating

[] slowing down [] other_____

Point of impact: [] rear-end [] head-on [] left front [] right front [] left rear [] right read

Visibility: [] poor [] fair [] good

Condition of road: [] icy [] wet [] sandy [] dark [] clean & dry

Amount damage to your vehicle: $_____ [] totaled

Seat belt on? [] Yes [] No

What position of your headrest at time of accident: [] straight [] left [] right

Did your body hit the inside of vehicle? [] No [] Yes - where?

_____

Did you lose consciousness during the injury? [] No [] Yes - where?

_____

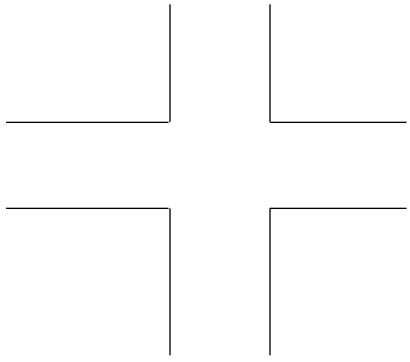
Did the police come? [] No [] Yes - Ticket given? [] No [] Yes - Written report? [] No [] Yes

Ambulance come? [] No [] Yes - Did you go to the ER with them?

What was done at the ER? Exam / X-rays / MRI / Other _____

Did you see any other doctors? [] No [] Yes - who? _____

Drawing the accident:



_____

Signature Date

LIEN AGREEMENT

I hereby authorize and direct you, my attorney, or Insurance company to pay directly to said doctors such sums as may be due and owing him/her for chiropractic service rendered to me both by reason of this accident and by reason of any other bills that are due his/her office and withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect and fully compensate said doctor.

I hereby further give Lien on my case to said doctor against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated or injuries in connections therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for service rendered to me and that this agreement is made solely for said doctor's addition protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I also fully understand that if payment is not made as agreed upon, (customer, buyer, client, etc.) shall be responsible for any and all interest (**at 1.75% per month or 21% per annum**). All reasonable attorney fees, cost of collection and court costs incurred, in efforts to enforce this agreement.

I hereby authorize my attorney to release *ultimate settlement figures, final disbursement and/or copy of settlement check* regarding my accident/injuries to Aim High Chiropractic.

I agree to promptly notify said doctor on any charge or addition of *attorney*(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due payable.

XX_____ _____

Patient's Signature **Date**

_____

Patient's Printed Name

_____ _____

Parent or Guardian's Signature **Date**

The undersigned being attorney of record for the above patient does agree to hold such sums for any settlement, judgement or verdict, as may be necessary to adequately protect and fully compensate said doctor and Aim High Chiropractic.

_____

_____

Attorney's Signature **Date**

_____

Attorney's Printed Name

Please sign, date and return one copy to doctor's office. Also keep a copy for your records.

AIM HIGH CHIROPRACTIC, PC.

50 S Federal Blvd.	1350 Chambers Rd, Ste 103	2532 Sheridan Blvd	7200 W. 44th Ave.
Denver, CO 80219	Aurora, CO 80011	Denver, CO 80214	Wheat Ridge, CO.80033
303-922-2977	303-577-2040	303-458-0294	303-423-1925

HEALTHCARE POWER OF ATTORNEY

BY THIS POWER OF ATTORNEY:

I, _____ (hereinafter, "Principal") of _____County of _____, in the state of Colorado, do appoint **Aim High Chiropractic, PC**
(hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said attorney is hereby authorized to:

1. Endorse any and all checks or forms of reimbursement made payable to principal (or members of principal's family) by any health insurance companies which relate to medical treatment provided by attorney to principal (or members of principals family) over to attorney.
2. Demand and direct any and all health insurance companies, during the course of principal's (or member of principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to Principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

GIVING AND GRANTING to said attorney full power and authority to do all and everything whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

I authorize Aim High Chiropractic to represent my interests in any and all disputes when payment for my claims have not been paid in part or in full. I authorize Aim High Chiropractic to represent me in the event a compliant must be made to the Colorado Insurance Commissioner.

All that said attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

Date: _____

_____
Print Name of Principal

⇨ XX _____
Principal's Signature

AIM HIGH CHIROPRACTIC, PC.

50 S Federal Blvd.	1350 Chambers Rd, Ste 103	2532 Sheridan Blvd	7230 W. 44TH Ave.
Denver, CO 80219	Aurora, CO 80011	Denver, CO 80214	Wheat Ridge, CO. 80033
303-922-2977	303-577-2040	303-458-0294	303-423-1925

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that this Chiropractic 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 Chiropractic Office will be credited to my account on 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 to me will be immediately due and payable.

XX Patient's signature:…….

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, lab procedures, chiropractic care or any clinic services that he/she deems necessary in my case. 1 further authorize him/her to disclose all or any part of my {patient's) records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

XX Patient's signature: ……

MY RESPONSIBILITY FOR PAYMENT OF FEES

I fully understand and agree that I am directly and fully responsible to pay this clinic, in full, for all professional services and/or products provided to myself and members of my family. I further understand and agree that such payment to this clinic is not contingent on any settlement, claim, judgement or verdict by which I may eventually recover said fee. I also agree to pay all reasonable costs of collection, attorney fees and interest at the ANNUAL PERCENTAGE RATE of 21% (1.75% PER MONTH) on any PAST DUE BALANCE (over 60 days old).

XX Patient's signature: …….

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: (Provider) _____Phone: ( ) _____Fax ( ) _____

I, _____ request the following information:
(Patient's name)

( ) X Ray ( ) History ( ) Records ( ) Diagnosis ( ) Treatment ( ) Reports ( ) Billings

concerning my: ( ) Accident ( ) Injury ( ) Other _____

To be sent to:

For Purpose of:

_____
(Specify)

<u>According to the Health and Safety Code, these records must be provided within 15 days of receipt of this notice.</u>

_____ have read and fully understand the above statements.
(Print Name)

⇨ **XX** _____ _____
(Signature) (Date)

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby and hereby grant permission for my child to receive chiropractic care.

AIM HIGH CHIROPRACTIC, PC.

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Aim High Chiropractic
50 South Federal Blvd.
Denver, Co 80219

Attorney Distribution Authorization Form

I hereby authorize my attorney, _____to release ultimate settlement figures, final disbursement and/or copy of settlement check regarding my auto accident on/injuries on_____

to Dr. _____ at Aim High Chiropractic, PC.

Patient Name (Print) _____

XXsigned by Patient/Parent/Guardian _____

Date: _____

ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT TO DOCTOR

Private, Group, Accident and Health Insurance

Accordance to legislation Bill HB1165-Bill 10-16-106.7, assignment of health insurance benefits—Concerning the payment of health insurance benefits to third persons holding an assignment from a covered person, I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Aim High Chiropractic, PC
50 S. Federal Blvd.
Denver, CO 80219
Telephone: (303) 922-2977
Fax: (303) 922-2044

HB1165-Bill 10-16-106.7 states "*The carrier shall honor the assignment and make payment of covered benefits directly to the provider. If the carrier fails to honor the assignment by making payment to the covered person and if the covered person, upon receipt of such payment, fails to pay an amount equivalent to such payment directly to the provider. It shall be the responsibility of the provider to notify the carrier if payment has not been received, in such case, the carrier shall make payment of covered benefits as specified in Section 10-16-106.5*"

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER HB1165-BILL 10-16-106.7**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorized the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Patient's Name _____

XX Patient's Signature _____ Date _____

Witness' Name _____ Date _____

Witness' Signature _____ Date _____

AIM HIGH CHIROPRACTIC, PC CLINICS:

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Disclosure of Fee's/Payment Policy (Chiropractic)

98940	CMT (1-2 regions)	$91.00		A9150 Supplement:	
98941	CMT (3-4 regions)	$108.00		Comb Adult	$22.00
98942	CMT (5 regions)	$113.00		Magnesium 1.0	$22.00
98943-51	CMT (extra spinal)	$89.00		A-Zact 25	$22.00
97112-52	Neuromuscular Reeducation	$70.90/$35.45		Baldrian Plus	$22.00
97012	Mechanical Traction	$48.95		Glucosamine	$22.00
97032-52	Manual EMS	$53.87/$26.93		Bone Support	$41.00
97535	Self-car/Home exercise	$75.00		Multivitamin	$18.00
99078	Physician Education/Workshop	$62.70		Joint X	$33.00
99204	NP Exam, Comprehen.(45min)	$260.00			
99203	NP Exam (30min)	$189.00			
99214-25	Re-exam expanded (45 min)	$155.00			
99213-25	Re-exam expanded (15 min)	$150.00			
72040	Cervical (2-3 views)	$179.00			
72050	Cervical (4+ views)	$279.00			
72070	Thoracic (2-3 views)	$179.00			
72100	Lumbosacral (2-3 views)	$179.00			
72020	Single view of spine	$129.00			
A9153	Biofree /Sombra	$22.00			
99070	Cervical Orthopedic Pillow	$79.20			
E0730	Tens Units	$549.00			
99070	Lumbar Orthopedic Pillow	$79.20			
97110	Therapeutic Exercise	$65.64			
97014	Electrical Stim. (unattended)	$51.21			
97530	Therapeutic Activities	$64.60			
97010	Hot/Cold Pack(s)	$45.00			
97810	Acupuncture	$110.00	First 15	min then $115 add 15 min	

Average cost per massage (includes manual traction) $180.00
ADBAE, foreign language interpretation $30.00/per 15 min

I have read the above codes and fees and understand the cost of my care with my treating doctor. These Fees are reasonable and customary.

I further understand that if my insurance company declines payment, I authorize Aim High Chiropractic PC to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.

Print **Signature** **Date**

AIM HIGH CHIROPRACTIC, PC CLINICS:

50 S Federal Blvd.
Denver, CO 80219
303-922-2977

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Aurora, CO 80011
303-577-2040

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Denver, CO.80214
303-458-0294

7200 W. 44th Ave
Wheat Ridge, CO. 80033
303-423-1925

HIPAA 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.

This is your Notice of Privacy Practices from Aim High Chiropractic, Inc. The Notice refers to Aim High Chiropractic by using the terms "us", "we," or "our." We are required by law to maintain the privacy of Personal Health Information. We are required to provide this Notice of Privacy Practices to you by the privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This notice describes how we protect the Personal Health Information we have about you that relates to your medical information or Personal Health Information. Personal Health Information is medical and other information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. (The HIPAA law uses the term "protected health information" where we use "Personal Health Information."). This Notice of Privacy Practices describes how we may use and disclose to others your Personal Health Information to carry out payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control of your Personal Health Information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all Personal Health Information that we maintain at that time. This notice may also be revised if there is a material change to the uses or disclosures of Personal Health Information, your rights, our legal duties, or other privacy practices stated in this notice. Within 60 days of a material revision to this notice we will provide you with a copy of the revised notice. Additionally, upon your request, we will provide you with any revised Notice of Privacy Practices by calling us at 303-922-2977 and requesting that a revised copy be sent to you in the mail.

How We May Use and Disclose Personal Health Information about You
The common reasons for which we may use and disclose your Personal Health Information are to process and review your requests for coverage and payments for benefits or in connection with other health related benefits or services in which you may be interested. The following describes these and other uses and disclosures and includes some examples.

For Treatment. We may use and disclose Personal Health Information to treat you. For example, you may be asked to undergo laboratory tests per your Updated physician's orders (such as blood or urine tests), and we will report the results back to your physician to be used in your treatment. Many of the people who work for us may use or disclose your Personal Health Information to treat you or to assist others in your treatment. Additionally, we may disclose your Personal Health Information to others who may assist in your care, such as your physician, therapists or medical equipment suppliers.

For Payment. We may use or disclose information for billing, claims management, collection activities, and obtaining payment under a contract for reinsurance and related healthcare data processing. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your Personal Health Information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your Personal Health Information to bill you directly for services and items.

For Healthcare Operation. We may use and disclose Personal Health Information about you for our health plan and insurance operations. For example we may use Personal Health Information to conduct quality assessment and improvement activities. We may also use or disclose Personal Health Information to review the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities. We may also use or disclose Personal Health Information for purposes of underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for healthcare provided that if we receive Personal Health Information for the purpose of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and if such health insurance or health benefits are not placed with us, we may not use or disclose such Personal Health Information for any other purpose, except as may be required by law. We may also use or disclose Personal Health Information to conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs. We may also use or disclose Personal Health Information for business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating an entity. We may also use and disclose Personal Health Information for the business management and general administrative activities of our entity (to the extent that such activities relate to functions that are covered under the federal HIPAA privacy laws.)

Other Purposes for which the Law Requires Us to Use or Disclose Personal Health Medical Information Without Your Written Authorization. The law requires that we disclose your Personal Health Information to you if you so request. This Notice provides the procedures we both must follow for us to disclose your Personal Health Information to you. The law also requires us to disclose Personal Health Information when required by the Secretary of the U. S. Department of Health and Human Services to investigate or determine our compliance with the requirements of the HIPAA privacy regulation.

Other Purposes for which the Law Allows Us to Use or Disclose Medical Information Without Your Written Authorization. We may disclose Personal Health Information to another healthcare provider, a healthcare clearinghouse, or a health plan for the payment activities of the entity that receives the information.

- We may disclose your Personal Health Information to another healthcare provider, a clearinghouse or a health plan for the healthcare operations activities of the entity that receives the information, if (1) each entity either has now or had in the past a relationship with you, (2) the Personal Health Information pertains to such relationship, and (3) the disclosure is for any of the following purposes: conducting certain quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; evaluating health plan performance; conducting certain training programs; accreditation; certification; licensing; credentialing activities; or healthcare fraud and abuse detection or compliance.
- We may use or disclose your Personal Health Information that is incident to an allowable use or disclosure if we have complied with the minimum necessary requirements and we have in place the appropriate administrative, technical, and physical safeguards, i.e. information and physical security safeguards, to protect the privacy of protected health information.
- We will use and disclose medical information about you when required to do so by law. Our use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. Examples of such required uses and disclosures are notifying public health authorities regarding public health activities including certain communicable diseases. Additionally, if required by law, or you agree, we would disclose Personal Health Information to the appropriate government authority if we think you have been the victim of abuse, neglect, or domestic violence. We may disclose Personal Health Information to a governmental agency or regulator with healthcare oversight responsibilities.
- We may also disclose Personal Health Information to a coroner or medical examiner to assist in identifying a deceased person or to determine the cause of death. We may disclose Personal Health Information to funeral directors as necessary to carry out their duties.
- We may also disclose Personal Health Information about you for workers' compensation or similar programs. We may disclose Personal Health Information is response to a request by a law enforcement official made via a court order, subpoena, warrant, summons or similar process.
- We may also disclose Personal Health Information to federal officials for national security and military activities authorized by law. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Personal Health Information to the correctional institution or

law enforcement official as authorized by law. If you or your estate is involved in a lawsuit or dispute, we may disclose Personal Health Information about you in response to a court or administrative order.

- We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the case, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- If you are an organ donor, we may disclose Personal Health Information about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- We also have the authority to comply with HIPAA and other federal laws and regulations to use and disclose Personal Health Information for research purposes. We may use and disclose Personal Health Information about you when necessary to prevent a serious threat to your health or safety or to the health and safety of another person or to the public.
- We may also disclose Personal Health Information about you to governmental agencies involved in disaster relief as well as to private disaster relief agencies to allow them to carry out their responsibilities in specific disaster situations. We may disclose Personal Health Information about you with third parties called Business Associates that perform various services (e.g., administrative, legal, actuarial, accounting, consulting or data services) for us. Whenever an arrangement between a Business Associate and us would involve the use or disclosure of your Personal Health Information, we will have a written contract protecting the privacy of Personal Health Information. We may use or disclose a portion of your Personal Health Information, called a Limited Data Set, only for the purposes of research, public health, or health care operations. We may use Personal Health Information to create a Limited Data Set or if we enter into a Data Use Agreement with a Business Associate we may disclose Personal Health Information to such Business Associate for the purpose of creating a Limited Data Set.
- Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke such authorization, in writing, at any time, except to the extent that we have taken action relaying on your authorization or if the authorization was obtained as a condition of obtaining your coverage with us. You should understand that we would not be able to take back any disclosures we may have made with authorization.

Your Rights Regarding Personal Health Information That We Maintain About You and How You May Exercise These Rights. You have the following rights with respect to your Personal Health Information that we maintain Your Right to Request Restrictions on Certain Uses and Disclosures of Personal Health Information:

- You may request that we restrict uses or disclosures of your Personal Health Information to carry out treatment, payment or healthcare operations.
- You may request that we restrict disclosures of your Personal Health Information to any person you identify for involvement in your care and for notification purposes, as applicable, regarding your location, general condition or death.
- We are not required to agree to your request for a restriction on uses or disclosures of your Personal Health Information to carry out treatment, payment or healthcare operations.
- If we agree to a restriction on uses or disclosures of your Personal Health Information to carry out treatment, payment, or healthcare operations, then we may not use or disclose Personal Health Information in violation of such restriction. However, if you are in need of emergency treatment and the restricted Personal Health Information is needed to provide the emergency treatment, we may disclose such information to a healthcare provider to provide such emergency treatment to you and we will request that such healthcare provider not further use or disclose your information.
- If we agree to a restriction, such restriction would not prevent uses or disclosures as follows: required by the U.S. Department of Health and Human Services to investigate or determine our compliance with the HIPAA privacy regulation; required by law; for public health activities; about victims of abuse, neglect, or domestic violence; for health oversight activities; for judicial and administrative proceedings; for law enforcement purposes; about decedents; for cadaveric organ, eye or tissue donation purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; or for workers' compensation.
- If we agree to a restriction, we may terminate that agreement if: you agree to or request the termination in writing; you orally agree to the termination and the oral agreement is documented by us; or we inform you that we are terminating our agreement to a restriction, except that such termination is only effective with respect to Personal Health Information created or received after we have so informed you.

Your Right to Receive Confidential Communications of Personal Health Information – We will accommodate any reasonable request you might make to receive communications of Personal Health Information from us by alternative means or at alternative locations, if you clearly inform us in writing that the disclosure of all or part of that Personal Health Information could endanger you.

- We require that you make a request for a confidential communication in writing and specify how or where you wish to be contacted.
- We may condition the provision of a reasonable accommodation on when appropriate, information as to how payment, if any, will be handled; and specification of an alternative address or other method of contact.
- You do not need to explain to us why you are requesting confidential communications.

Your Right to Inspect and to Copy Personal Health Information – You have a right of access to a copy of your Personal Health Information, except for conditions regarding "Unreviewable Grounds for Denial of Access" and "Reviewable Grounds for Denial of Access" listed below, you have the right of access to inspect and to obtain a copy of your Personal Health Information that we maintain in a Designated Record Set, for as long as the Personal Health Information is maintained in the Designated Record Set, except for psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We require you to make requests for access in writing.

Unreviewable Grounds for Denial of Access – We may deny you access to your Personal Health Information without providing you an opportunity for review, in the following circumstances:

- The Personal Health Information is not something to which you have a right of access.
- The Personal Health Information is contained in records that are subject to the federal Privacy Act and your access to it may be denied, if the denial of access under the Privacy Act would meet the requirements of that law.
- The Personal Health Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access you requested would be reasonably likely to reveal the source of the information.

Reviewable Grounds for Denial of Access – We may deny you access to your Personal Health Information, provided that we give you the right to have such denials reviewed (as required by the Review of a Denial of Access procedures listed below) in the following circumstances:

- A licensed healthcare professional determines that the access you requested is reasonably likely to endanger the life or physical safety of you or another person;
- The Personal Health Information makes reference to another person (unless such other person is a healthcare provider) and a licensed healthcare professional determines that the access you requested is reasonably likely to cause substantial harm to such other person; or

- The request for access is made by your personal representative and a licensed healthcare professional determines that the provision of access to such personal representative is reasonably likely to cause substantial harm to your or to another person.

Review of a Denial of Access – If we deny you access to your Personal Health Information on a ground that qualifies as a Reviewable Ground for Denial of Access, you have the right to have the denial reviewed by a licensed healthcare professional who is designated by us to act as a reviewing official and who did not participate in the original decision to deny access. We will promptly provide written notice to you or to your personal representative (as applicable) of the determination of the designated reviewing official and we will carry out the designated reviewing official's determination.

We Will Respond Promptly to Your Request for Access to Personal Health Information under the following conditions:

- If you request access to Personal Health Information that is not maintained by us or is not accessible to us on-site, we will, no later than 60 days from the receipt of your request, take one of the following actions:
- If we grant your request we will inform you of our acceptance of your request and we will provide you the access requested in accordance with the Provision of Access requirements listed below.
- If we deny your request we will provide you with a written denial in accordance with the Denial of Access requirements listed below.
- If we are unable to meet these requirements within the 60 day time period, we may have an additional 30 days (a total of 90 days) to either accept or deny your request for access if during the first 60 day period we provide you with a written statement of the reasons for the delay and the date by which we will complete our action on your request for access.
- If you request access to Personal Health Information that is maintained by us or is accessible to us on-site, we will act on such a request no later than 30 days after receiving your request as follows:
- If we grant your request for access we will inform you of our acceptance of your request and provide the access requested in accordance with the Provision of Access requirements listed below.
- If we deny your request we will provide you with a written denial in accordance with the Denial of Access requirements listed below.
- If we are unable to meet these requirements within the 30 day time period, we may take up to an additional 30 days (a total of 60 days) for such actions by, within the first 30 day period, providing you with a written statement of the reasons for our delay and the date by which we will complete our action on your request for access to your Personal Health Information.

Provision of Access – If we provide you access to your Personal Health Information, we will do so by adhering to the following requirements:

- Providing the Access Requested. We will provide the access requested by you of the Personal Health Information we maintain about you in Designated Record Sets.
- Form of Access Requested.

We will provide you with access to the Personal Health Information in the form you request, in a hard copy form or another form upon which we both agree.

We may provide you with a summary of the Personal Health Information requested, in lieu of providing you access to your Personal Health Information or we may provide an explanation of the Personal Health Information to which access has been provided, if you agree in advance to such a summary or explanation and you agree in advance to the fees imposed, if any, by us for such summary or explanation.

- Manner of Access. We will arrange with you for a convenient time and place for you to inspect or to obtain a copy of your Personal Health Information, or we will mail a copy of the Personal Health Information at your request.
- Fees. If you request a copy of your Personal Health Information or agree to a summary or explanation of such information, we may impose a reasonable, cost-based fee.

Denial of Access – If we deny you access, in whole or in part, to your Personal Health Information, we will do so only by adhering to the following requirements:

- To the extent possible, we will give you access to any other of your Personal Health Information requested, after excluding the Personal Health Information as to which we have a ground to deny you access.
- Provide you with a timely, written denial.
- If we do not maintain the Personal Health Information that is the subject of your request for access, and we know where the requested information is maintained, we will inform you where to direct your request for access.

Your Right to Amend Personal Health Information – You have the right to have us amend Personal Health Information or a Record about you maintained in a Designated Record Set for as long as we maintain the Personal Health Information in the Designated Record Set.

Denial of Amendment – We may deny your request for amendment of Personal Health Information or a Record about you maintained in a Designated Record Set, if we determine that the Personal Health Information or Record that is the subject of the request:

- Was not created by us, unless you provide us with a reasonable basis to believe that the originator of Personal Health Information is no longer available to act on the requested amendment;
- Is not part of the Designated Record Set;
- Would not be available for inspection under the rights that the HIPPA privacy regulation gives to individuals to access Personal Health Information; or
- Is accurate and complete.

Requests for Amendment and Timely Action – You may request that we amend your Personal Health Information that we maintain in a Designated Record Set. You must make such requests for amendments in writing and provide us with a reason that supports your proposed amendment. We will act on your request for an amendment no later than 60 days after receiving your request as follow:

- If we grant your requested amendment we will make the amendment, inform you and inform certain others.
- If we deny your requested amendment we will provide you with a timely written denial that uses plain language and contains the basis for the denial of an amendment. The denial notice will also include other information regarding future disclosures of your Personal Health Information and how you may disagree with or complain about our denial of your amendment.
- If we are unable to act on your request to amend your Personal Health Information that we maintain in a Designated Record Set, within 60 days after receiving your request, we may take up to an additional 30 days to act on your request, by, within 60 days after receiving your request for an amendment, providing you with a written statement of the reasons for our delay in acting on your request and the date by which we will complete our action on your request.

Actions on Notices of Amendment – When we are informed by a healthcare provider, a healthcare clearinghouse or another health plan of an amendment to your Personal Health Information then we will amend your Personal Health Information that we maintain in a Designated Record Sets by, at a minimum, identifying the Records in the Designated Record Set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

Your Right to Receive an Accounting of Our Disclosures of Your Personal Health Information – You have the right to receive an accounting of Disclosures of Personal Health Information made by us in the 6 years before the date of your request for the accounting.

Disclosures NOT required to be listed in the Accounting – The following are disclosures to which you do not have a right to an accounting and we will not include a listing of such disclosures to you.

- Disclosures made to carry out our payment activities and purposes.
- Disclosures made to carry out our healthcare operations activities and purposes.
- Disclosures made by us for the treatment activities of a healthcare provider.
- Disclosures made by us to a healthcare provider, a healthcare clearinghouse, or another health plan for the payment activities of the entity that receives the information.
- Disclosures made by us to a healthcare provider, a healthcare clearinghouse, or another health plan for certain healthcare operations activities of the entity that receives the information, if we and the entity receiving the information either has or had a relationship with you, the Personal Health Information pertains to such relationship, and the disclosure is for certain limited purposes.
- Disclosures of your Personal Health Information made to you.
- Disclosures made incident to a use or disclosure otherwise permitted or required by the HIPAA privacy regulation.
- Disclosures made pursuant to your authorization.
- Disclosures made pursuant to the HIPAA privacy regulation regarding those disclosures made to persons involved in your care or other notification purposes.
- Disclosures made for national security or intelligence purposes to authorized federal officials for the conduct of lawful national security activities.
- Certain disclosures made to correctional institutions or law enforcement officials having lawful custody of you or other Personal Health Information about you.
- Disclosures that are part of a Limited Data Set under the HIPAA privacy standards and implementation specifications regarding Limited Data Sets and Data Use Agreements.
- Disclosures that occurred before April 14, 2017.

Under certain circumstances we are required to temporarily suspend your right to receive an accounting of the disclosures we made to a health oversight agency or law enforcement official. You have the right to request from us an Accounting of Disclosures for a period of time less than 6 years from the date of your request. Unless the disclosure is one that we are not required to list in the accounting, or you have requested a time period of less than 6 years, the written Accounting of Disclosures will include disclosures of your Personal Health Information that occurred during the 6 years before the date of your request for an Accounting, including disclosures to or by our Business Associates. Provision of the Accounting of Disclosures of Your Personal Health Information – Within 60 days after receiving your request for an Accounting of Disclosures of your Personal Health Information, we will provide you with such an accounting. If we are unable to provide an accounting of disclosures within the 60 day period, we may take an additional 30 days on which to provide the accounting by providing you, within 60 days after receiving your request for an accounting, a written statement of the reasons for our delay and the date by which we will provide to you an Accounting of Disclosures of your Personal Health Information.

Fees for an Accounting Disclosure – The first accounting of disclosures that you request within any 12 month period will be provided to you by us at no charge. For any additional accountings of disclosures that you make within a 12 month period we will charge you a reasonable, cost-based fee. We will notify you in advance of this fee, and you will have the opportunity to withdraw or modify your request for a subsequent accounting of disclosures of your Personal Health Information in order to avoid or reduce the fee.

Your Right to Receive a Paper Copy of This Notice. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically. At least once every three (3) years, we will notify all individuals covered by our plan of the availability our Notice of Privacy Practices and how to obtain the notice.

Your Right to File a Complaint. If you think that we have violated your privacy rights, you have the right to file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact our privacy supervisor. All complaints must be submitted to us in writing. We will not penalize you nor will we retaliate against you for filing a complaint.

Contact Information. For further information about matters covered by this notice please contact Privacy Officer at 303-922-2977.

Omnibus Final Rule

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information technology for Economic and Clinical Health (HITECH) Act, are as follows:

- You have the right to be notified of a data breach.
- You have the right to ask for a copy of your electronic medical record in an electronic form.
- You have the right to opt out of fundraising communications from AHC, and AHC cannot sell your health information without your permission.
- Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in this notice will be made only with your authorization.
- If you pay in cash in full (out of pocket) for your treatment, you can instruct AHC not to share information about your treatment with your health plan.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number 303-922-2977.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____

Signature:_____ Date:_____