Dr. Oscar Castro Chiropractic

HIPAA Notice of Privacy Practices

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.

Dr. Oscar Castro is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage you health care and any other related services. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your heath care services.

Healthcare Operations: We may call you by name in the waiting room when the doctor is ready to see you. We may use or disclose your protected health information to contact you to remind you of your appointment. We will disclose your protected health information without your authorization if it is Required by Law, Public Health issues required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Coroners, Funeral Directors, Organ Donation, Criminal Activity Research, including Military and National Security, Workers Compensation. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law (you may revoke this authorization at any time in writing).

Your Rights: You have the right to inspect and copy your protected heath information. Under federal law, however, you may not inspect or copy information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office of you complaint. We will not retaliate against you for filing a complaint. 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 protected health information. If you have any objections to this form, please ask to speak with Dr. Oscar Castro in person. If Dr. Oscar Castro is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to the DHHS, Office of Civil Rights in Washington, DC. The effective date of this notice is July 2, 2012.

PATIENT CARE AGREEMENT

AS A PATIENT OF Dr. Oscar Castro. I AGREE TO THE FOLLOWING:

- If for any reason my insurance company does not make a complete payment to Dr. Oscar Castro within 60 days of my office visit, I understand that I will be sent a bill explaining my amount due.
- In event that my insurance company denies payment or applies the visit charges to my deductible, I understand that I am responsible for the amount billed by Dr. Oscar Castro.
- In the event that my case is an accident, personal injury, or workman's compensation, I understand Dr. Oscar Castro will pursue all efforts to receive payment from the responsible parties. However, once a year has passed from my discharge date and payment has not been made to Dr. Oscar Castro I understand that I am responsible for the amount billed by Dr. Oscar Castro I will be refunded should Dr. Oscar Castro ever receive payment in the future.
- If a check that I have written to Dr. Oscar Castro is returned, I understand that I am responsible for the amount of the check plus any related service fees charged Dr. Oscar Castro
- If for any reason I am unable to make my appointment and I do not notify Dr. Oscar Castro at least one hour before the appointment time, I will be charged a $25 fee for the missed appointment.

We at Dr. Oscar Castro strive to make your visit worthwhile, and by providing these guidelines, we can continue to offer you the best possible care. If you have any questions or need to make special payment arrangements, please feel free to call us and discuss it. We appreciate your cooperation.

WORKING WITH A HEATHCARE PROVIDER IS A PARTNERSHIP OF SHARED RESPONSIBILITY

OUR RESPONSIBILITY:

1. We will provide a friendly, helpful and courteous staff.
2. You will be seen within minutes of arriving for your appointment – no long waiting times.
3. We will provide a clear explanation of any health problems and the strategies to solve them.
4. We will help to verify your insurance to see what is and what is not covered.
5. We will submit your insurance claims using the appropriate codes and notes, given that you have provided us with your most up-to-date insurance information.
6. After 30 days, if your insurance has not responded, we will resubmit the entire claim.
7. If your insurance company has not responded or paid the entire bill after 60 days, we will then bill you. We will expect this bill to be paid within 30 days.

YOUR RESPONSIBILITY:

1. We realize that life is hectic and unpredictable. If you cannot make a scheduled appointment, we expect a phone call no less than one hour before your appointment. We give everyone one (1) warning but from then on we will charge your account $25 for any missed appointments.
2. The Doctor will recommend specific exercises, stretches, nutrients and activities to limit/avoid. If you should choose not to follow the recommendations, which is your prerogative, you may find that your results are less than optimal. Remember: the Chinese define insanity as doing the same behavior and expecting different results.
3. If your insurance does not pay for your visit for any reason, you will be sent a bill which you need to pay within 30 days.
4. We recommend that you also verify your insurance (if possible, prior to your visit) to avoid any confusion.
5. Please notify us with any changes in your insurance, billing or address information so we can keep your file current.

PAYMENT POLICY

As a courtesy to our patients, we offer various billing choices. Although we at Dr. Oscar Castro will contact your insurance company or attorney to verify your benefits, we recommend that you also call in order to fully understand your plan options. If you are aware of any limitations on your insurance benefits, please notify us immediately to allow us to try to maximize your coverage.

SELF PAY
I will pay for all services as they are rendered on the date of my visit. I understand that I may contact Dr. Oscar Castro for required documentation if I choose to submit my own insurance claims.

INSURANCE SUBMITTAL
I would like to assign my insurance benefits to Dr. Oscar Castro and have you submit my insurance claims for me. If Applicable, I understand that I am responsible for obtaining any necessary preauthorization from my primary care physician. I understand that I am responsible for any balance as billed to me by Dr. Oscar Castro that results from co-payments, deductibles, or non-covered services. I will also sign over to Dr. Oscar Castro within 5 business days any insurance checks mailed to me that are owned for services received at Dr. Oscar Castro.

AUTO ACCIDENT/PERSONAL INJURY CLAIM
I was involved in an accident and would like to assign benefits to Dr. Oscar Castro and have you submit all charges to my insurance/attorney for me. I will sign all liens necessary to protect your office. I also understand that, regardless of the settlement, I am personally responsible for the entire balance. If Dr. Oscar Castro is not paid within 30 days of the case settlement, I will personally pay the entire overdue balance.

WORKER'S COMPENSATION CLAIM
I was involved in an injury at work. I will ensure that my employer files the appropriate paperwork as needed Dr. Oscar Castro to receive compensation. I understand that it is in my rights as California resident to have any bills paid that are incurred as a result of a work related injury. If after 60 days of my visit to Dr. Oscar Castro my claim is not paid, I understand that I am responsible for the overdue balance.

We at Dr. Oscar Castro strive to make your visit worthwhile, and by providing these guidelines, we can continue to offer you the best possible care. If you have any questions or need to make special payment arrangements, please feel free to call us and discuss it.

By signing below, you acknowledge and understand your privacy rights contained in this notice. Your signature authorizes Dr. Oscar Castro to use and disclose your protected health information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

_____	_____	_____
Signature	Print name	Date

Updated: 03/15/2015