

**DR. SARAH F. WILLIAMS DC, MS, CCH (NA)**  
**Notice of Privacy Practices and Patient Rights under HIPAA**

This notice summarizes how your health information may be used and disclosed and how you can access your health information. Please review this information carefully.

If you have any questions, please ask us.

We typically use or share your health information in the following ways:

- In the course of providing health care for you, we can use your health information and share it with other professionals who are treating you.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary, including sending you appointment reminders.
- We can use and share your health information to bill and get payment from health plans or other entities related to your care.

We are allowed or required to share your health information in other ways - usually ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- *Help with public health and safety issues.* We can share health information about you for certain situations such as:
  - Preventing disease.
  - Helping with product recalls.
  - Reporting adverse reactions to medications.
  - Reporting suspected abuse, neglect, or domestic violence.
  - Preventing or reducing a serious threat to anyone's health or safety
- *Comply with the law.* We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see if we are complying with federal privacy law
- *Address workers' compensation, law enforcement, and owner government requests.* We can use or share health information about you:
  - For workers' compensation claims.
  - For law enforcement purposes or with a law enforcement official.
  - With health oversight agencies for activities authorized by law.
  - For special government functions such as military, national security and presidential protective services.
- *Respond to legal actions.* We can share health information about you in response to a court order or administrative order, or in response to a subpoena.
- *Do research.* We can use or share your information for health research.

For certain health information, you can tell us about your choices about what we share.

- If you have a clear preference for how we share the information described in the instances below, please talk to us. In these cases, you have both the right and the choice to tell us to:
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.

If you are not able to tell us your preference, for example, you are unconscious; we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

**Dr. Sarah William DC, MS, CCH (NA)**

**Concord:** Concord Health Center, 55 Winthrop Street, Concord, MA, 01742 | (978) 369-3604

**Nantucket:** 30 Shinmo Pond Road, Nantucket, MA 02554 | (508) 221-5012

Fax (978) 369-5205 | [www.drsarahwilliams.com](http://www.drsarahwilliams.com)

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**You have the right to:**

- *Get a copy of your paper or electronic health record.* Every time you visit one of our offices or have an appointment by phone or video, your health and financial information are recorded for the purposes of providing our services and for billing. If you would like a copy or summary of your health information, you must submit a request in writing to Dr. Sarah Williams. We will provide you a copy or summary of your health information within 30 days of receipt of your written request. We may charge a fee for the costs associated with processing your request.
- *Ask us to amend or correct your health information.* If you think that the health information in your health record is incomplete or incorrect, you may ask us to amend or correct this information. To do so, you must submit a written request to Dr. Sarah Williams, which includes the reason for your request. We may deny your request (Should this be the case, we will tell you the reason for the denial in writing within 60 days) under the Following circumstances:
  - The information in question was not created by us.
  - The information in question is not part of the health information kept by us.
  - The information in question is accurate and complete.
- *Request confidential communications.* You may ask us to contact you in a specific manner or at a specific location (for example, you may ask us to contact you only by mail to your post office box or to call you only at your home phone). We will accommodate all reasonable requests. You must submit your request in writing to Dr. Sarah Williams and include:
  - How and where you wish to be contacted.
- *Ask us to limit what information we use or share.* You may ask us not to use or share certain health information for treatment, payment or for our operations/services. We are not required to agree with your request and we will say "no" if it would affect your care. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. This request must be submitted in writing to Dr. Sarah Williams and must include the following:
  - Which information you want us to limit/restrict access to
  - Whether you want to limit us or our disclosure or both.
  - To whom this limitation applies, for example, disclosures to a family member.
- *Ask us for a list of those with whom we've shared information.* You may ask for a list (accounting) of the times we've shared/disclosed your health information for six years prior (on or after April 13, 2003) to the date you ask as well as with whom we shared it and why. You must submit your request in writing to Dr. Sarah Williams. We will include all disclosures except those used for the purposes of providing our services, payment, and health care operations and certain other disclosures (such as any that you asked us to make). We will provide one accounting per year for free, but we will charge you for a cost-based fee for any additional accounting requests received within 12 months.
- *Ask for a copy of this privacy notice.* You may ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically.
- *Choose someone to act for you.* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that person has the authority to act for you before we take any action.
- Any patient believing that his or her privacy rights have been violated may file a complaint with us by contacting the office manager or the Secretary of the Department of Health & Human Services.

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**Our Responsibilities:**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy and security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your health information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For further information about Dr. Sarah Williams' privacy policy and this notice, please contact us at:

Telephone: (978)-369-3604 | Fax: (978)-369-5205

**Changes to the Terms of this Notice**

*We can change the terms of this notice, and the changes will apply to all information we have about you. This new notice will be available in our office and upon request.*

*Effective date: July 31, 2017*

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**Informed Consent:**

I hereby request and consent to treatment(s) by Dr. Sarah F. Williams DC, MS, CCH (NA) including but not limited to nutritional assessment, dietary counseling, and laboratory testing. I acknowledge that no warranties have been made regarding the results achieved under Dr. Sarah Williams' care. I do understand that, as with any wellness program, there are certain associated risks. I do not expect Dr. Sarah F. Williams DC, MS, CCH, (NA) to be able to anticipate all of the risks and possible complications. I intend this consent to cover the entire course of care for my present condition and for future conditions for which I seek treatment.

**Payment & Insurance:**

Our office requires that payment be received for services rendered at the time of your visit. You may pay with your credit card, check or cash. We do not take insurance for office visits. Dr. Williams does not participate in, take assignment, or accept any private insurance. We do not provide superbills and cannot assist with claim resolution for laboratory tests or consultations.

**Rescheduling/Cancelling Appointments:**

Your time and health are both precious. In order to facilitate your ongoing care and make the best use of your time, we also offer phone consultations and video "telehealth" appointments using Zoom. For videoconferences, please make sure that your camera is working and that you have downloaded the Zoom link we will provide to your PC or Mac. Should you need to reschedule or cancel an appointment, we kindly ask that you notify us 24 hours before your scheduled appointment. Appointments that are not canceled or rescheduled 24 hours in advance will be subject to a missed appointment fee.

**Collection Costs:**

In the event that it becomes necessary to use collection procedures, your signature below constitutes your agreement to pay for any and all collection agency fees, costs, and expenses.

**Privacy:**

Dr. Sarah F. Williams DC, MS, CCH, (NA) places the highest priority on the client's right to privacy. Our office staff is trained to protect your health information. We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. Please see our Notice of Privacy Practices & Patient Rights Under HIPAA listed on our website ([www.drSarahWilliams.com](http://www.drSarahWilliams.com)) or ask us for a copy.

My signature below constitutes:

- My consent to treatment, including but not limited to laboratory testing, by Dr. Sarah Williams DC, MS, CCH, (NA) and to the office policies & terms/conditions as stated above.
- My acknowledgement of receipt of a copy of this office's Notice of Privacy Practices and Patient Rights under HIPAA.
- My permission for Dr. Sarah F. Williams DC, MS, CCH, (NA) and Staff to contact me by (please check all methods of contact that apply and provide associated contact information):

- ☐ Email: \_\_\_\_\_

My signature below constitutes that I understand the risks of unencrypted email and give Dr. Sarah F. Williams & Staff permission to communicate with me by email and send me lab results per email.

- ☐ Phone: \_\_\_\_\_

Dr. Williams and Staff may/may not leave a message on my voicemail or answering machine if I am unavailable to take their call.

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- \_\_\_\_ Regular Mail: \_\_\_\_\_
- \_\_\_\_ Text Message: Phone number \_\_\_\_\_
- To comply with the Telephone Consumer Protection Act, consent is required to send our patients automated phone calls and text messages regarding scheduled appointment reminders.
- \_\_\_\_ Yes, I consent to receive text reminders. \_\_\_\_ No, I do not consent to receive text reminders.

**Patient Name:** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Patient / Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

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