POSITIVE CHIROPRACTIC
SOLUTIONS

Case History/Patient Information

Date: _____ Patient #: _____ Doctor: _____

Name: _____ Social Security #: _____-_____-_____

Street: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: (M S) Race: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: (M F) Height: _____ Weight: _____

Occupation: _____ Employer: _____

Spouse: _____ Children (ages): _____

Medical Doctor: _____ Referred To Our Office By: _____

Previous Chiropractic Care: _____

Past & Present Medical History

Please check if you have or have had any of the following:

□ Headaches	□ Weakness in Extremities	□ Broken Bones	□ Hepatitis
□ Neck Pain	□ Hand Numbness/Tingling	□ Eye/Vision Problems	□ HIV Positive
□ Mid Back Pain	□ Foot Numbness/Tingling	□ Hearing Problems	□ Osteoporosis
□ Low Back Pain	□ High Blood Pressure	□ Ringing/Buzzing in Ears	□ Loss of Memory
□ Arm Pain/Numbness/Tingling	□ Diabetes	□ Breathing Problems	□ Fatigue
□ Leg Pain/Numbness/Tingling	□ Stroke/Heart Attack	□ Chest Pain/Tightness	□ Stomach Problems
□ Muscle Spasm	□ Cancer	□ Pacemaker	□ Circulation Problems
□ Joint Stiffness	□ Arthritis	□ Menstrual Difficulties	□ Ulcers
□ Stiff Neck	□ Difficulty urinating	□ Depression/Other disorders	□ Fever
□ Sleeping Problems	□ Unusual Bowel Patterns	□ Tension/Irritability	□ Heart Disease
□ Dizziness/Loss of Balance	□ Epilepsy/Seizures	□ Alcoholism	□ Neurological Disorder
□ Fainting	□ Significant Weight Change	□ Drug Addiction	□ Prostate Problems
□ Foot/Ankle/Knee/Hip Pain	□ Hand/Wrist/Elbow Pain	□ Shoulder Pain	□ Spinal Cord Injury

List and describe any other medical history not listed above:

_____

_____

Operations/Surgeries (include date if applicable):

□ Appendix	□ Neurological	□ Elbow: R or L	□ Cervical Spine/ Disc
□ Chest	□ Ears/Nose/Throat	□ Shoulder: R or L	□ Thoracic Spine/Disc
□ Gallbladder	□ Brain/Tumor	□ Foot/Ankle: R or L	□ Lumbar Spine/Disc
□ Hernia	□ Heart Bypass	□ Knee: R or L	□ Neck
□ Heart	□ Podiatric	□ Hip Replacement: R or L	□ Back
□ Obstetrical	□ Hand/Wrist: R or L	□ Knee Replacement: R or L	□ Cosmetic
□ Gastrointestinal	□ Other:		

Patient Name: _____ *Patient #:* _____ *Date:* _____

Please list any Medications and/or supplements you are currently taking:

_____

_____

Traumas/Accidents (please describe, give dates, injuries, broken bones, treatment if applicable):

- Automobile: _____
- Occupational: _____
- Recreational: _____
- Childhood: _____
- Other: _____

Have you ever been hospitalized? _____ Yes _____ No

If yes, please describe the reason(s): _____

What is the date of your last physical exam/bloodwork? _____

Have you had any x-ray/CT/MRI/Ultrasound tests done in the past year? _____ Yes _____ No

If yes, date and type of imaging performed: _____

Location/Doctor who performed the above imaging: _____

Women: Are you pregnant? _____

Allergies (please check all applicable):

□ Animals	□ Pain Medication	□ Shellfish/Iodine	□ Chocolates/Sweets
□ Dairy	□ Penicillin	□ Bee Stings	□ Wheat
□ Molds	□ Other Medication	□ Eggs	□ Soaps
□ Seasonal Allergies	□ Latex	□ Peanuts	□ Polyester
□ Dust	□ Rubber	□ Other:	

Health Questions (Check/answer all that apply):

Do you smoke? _____ Drink alcoholic beverages? _____ Use recreational drugs? _____

Eat a well-balanced diet? _____ Drink water regularly? _____ Sleep 6-8 hours? _____

Exercise? _____ How Stressed do you feel? _____ (none, mild, moderate, high)

Do you have any hobbies (please list): _____

Patient Name: _____ *Patient #:* _____ *Date:* _____

FAMILY HISTORY

(Please Check all that Apply)

CONDITION	GRANDPARENTS (PGF, PGM, MGF, MGM) Ex. Paternal Grandfather = PGF	MOTHER	FATHER	SIBLING(S)	CHILDREN Ages: _____
Arthritis					
Asthma					
Back Trouble					
Bursitis					
Cancer					
Constipation					
Diabetes					
Disc Problem					
Emphysema					
Epilepsy					
Headaches					
Heart Trouble					
High Blood Pressure					
Kidney Trouble					
Liver Trouble					
Migraine					
Neuralgia					
Pinched Nerve					
Scoliosis					
Sinus Trouble					
Stomach Trouble					
Stroke					
Other:					

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Patient Name: _____ *Patient #:* _____ *Date:* _____

What is your MAIN complaint? _____ Date problem began: _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ YES □ NO If yes, when was your last episode of this pain? _____

How often do you experience your symptoms?

□ Intermittently (0-25% of the day) □ Occasionally (26-50% of the day)

□ Frequently (51-75% of the day) □ Constantly (76-100% of the day)

Describe the nature of your symptoms:

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain □ Tightness

□ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0 = NO PAIN and 10 = EXCRUCIATING PAIN)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Does your pain radiate? □ YES □ NO If yes, where does it radiate to? _____

What activities make your condition WORSE (working, exercise, sitting, etc.)? _____

What activities make your condition BETTER (ice, heat, medication, etc.)? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

No problem 0 1 2 3 4 5 6 7 8 9 10 Cannot perform activities

What is your SECOND complaint? _____ Date problem began: _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ YES □ NO If yes, when was your last episode of this pain? _____

How often do you experience your symptoms?

□ Intermittently (0-25% of the day) □ Occasionally (26-50% of the day)

□ Frequently (51-75% of the day) □ Constantly (76-100% of the day)

Describe the nature of your symptoms:

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain □ Tightness

□ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0 = NO PAIN and 10 = EXCRUCIATING PAIN)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Does your pain radiate? □ YES □ NO If yes, where does it radiate to? _____

What activities make your condition WORSE (working, exercise, sitting, etc.)? _____

What activities make your condition BETTER (ice, heat, medication, etc.)? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

No problem 0 1 2 3 4 5 6 7 8 9 10 Cannot perform activities

Patient Name: _____ *Patient #:* _____ *Date:* _____

What is your THIRD complaint? _____ Date problem began: _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ YES □ NO If yes, when was your last episode of this pain? _____

How often do you experience your symptoms?

□ Intermittently (0-25% of the day) □ Occasionally (26-50% of the day)

□ Frequently (51-75% of the day) □ Constantly (76-100% of the day)

Describe the nature of your symptoms:

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain □ Tightness

□ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0 = NO PAIN and 10 = EXCRUCIATING PAIN)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Does your pain radiate? □ YES □ NO If yes, where does it radiate to? _____

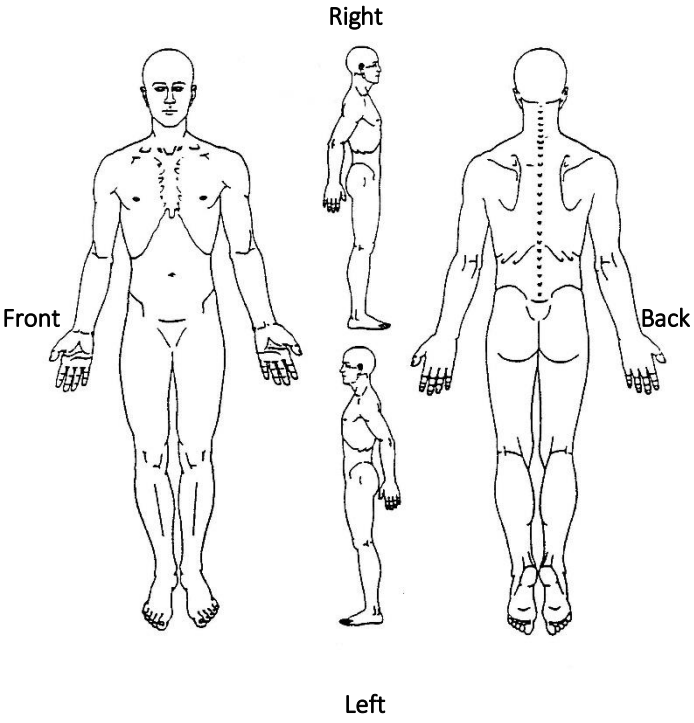
What activities make your condition WORSE (working, exercise, sitting, etc.)? _____

What activities make your condition BETTER (ice, heat, medication, etc.)? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

No problem 0 1 2 3 4 5 6 7 8 9 10 Cannot perform activities

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW:



Main Reason for Consulting This Office:

- □ Become Pain Free
- □ Reduce Symptoms
- □ Resume normal activity level
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Second Opinion on my condition
- □ Wellness/Maintenance Care

Patient Name: _____ *Patient #:* _____ *Date:* _____

AUTO ACCIDENT INFORMATION

Please Provide A Picture ID, Your Auto, and Health Insurance Card

Auto Insurance Company: _____
Date of Accident: _____ State Accident Occurred: _____
Have you notified your Auto Insurance Carrier: □ Yes □ No
If yes, were you assigned a Claim Number: □Yes □ No
If yes, Claim Number: _____
If Name Is Different From the Policy Holder (Policy Holder Is: Parent or Spouse)
Policy Holder's Name: _____ S.S. #: _____ - _____ - _____ Policy Holder's Date of Birth: _____ Age: _____ Gender: Male or Female

Health Insurance Company:
Policy Number: _____ Group # : _____
If Name Is Different From the Policy Holder (Policy Holder Is: Parent or Spouse)
Policy Holder's Name: _____ S.S. #: _____ - _____ - _____
Policy Holder's Date of Birth: _____ Age: _____ Gender: Male or Female

Date of Accident/Injury: _____ Time of Day: _____ □ AM □ PM

I was: □ Driver I was: □ Passenger

□ Front Middle Seat □ Front Right Seat

□ Rear Left Seat □ Rear Middle Seat □ Rear Right Seat

If Other than Yourself, The Driver was: _____

What type of vehicle were you in? _____

What type was the other vehicle? _____

Speed your vehicle was traveling at time of impact: _____

Speed other vehicle was traveling at time of impact: _____

I was stopped at: □ Stop Sign □ Traffic Signal □ Due to traffic □ Other: _____

I was traveling: □ Forward □ Backward □ Turning Right □ Turning Left

My vehicle was struck on: □ Front Left □ Front Center □ Front Right □ Passenger Side

□ Rear Left □ Rear Center □ Rear Right □ Driver Side

I struck other vehicle on: □ Front Left □ Front Center □ Front Right □ Passenger Side

□ Rear Left □ Rear Center □ Rear Right □ Driver Side

Impact caused my vehicle to: □ Hit another vehicle □ Hit a Pole □ Hit a Wall □ Hit a Fence □ Spin out of control □ Flip over □ Other: _____

Patient Name: _____ *Patient #:* _____ *Date:* _____

Amount of damage sustained to my vehicle: □ None □ Minimal □ Mild □ Moderate □ Severe □ Totaled

Amount of damage sustained to other vehicle: □ None □ Minimal □ Mild □ Moderate □ Severe □ Totaled

Wearing a Seatbelt: □ Yes □ No **Air Bag Deployed**: □ Yes □ No

If child, restrained: □ Car Seat □ Booster Seat □ Other: _____

I Struck my:	…against:				
□ Head	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Face	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Chest	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Right Shoulder	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Left Shoulder	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Right Leg	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Left Leg	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Right Knee	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Left Knee	□ Windshield	□ Steering Wheel	□ Dashboard	□ Headrest	□ Door
□ Other:					

Please write in your own words how the accident/injury occurred:

At the time of the Accident:

I had loss of consciousness: □ Yes □ No

Immediately **following the accident did you feel**:

□ Dizzy □ Weak □ Dazed □ Nervous □ Disoriented □ Nauseated □ Other: _____

List all areas that you immediately felt pain in: _____

_____

Lis all areas that you had bruises to: _____

_____

List all areas that you had cuts to: _____

_____

Patient Name: _____ *Patient #:* _____ *Date:* _____

Police responded to scene of accident: □ Yes □ No

Citations issued: □ None □ Yourself □ Driver of vehicle in which you were passenger

□ Driver of other vehicle □ Unsure

Fire Rescue Responded to scene of accident: □ Yes □ No

If yes, what did Fire Rescue/Paramedics perform:

□ Nothing □ Cut me out of vehicle □ IV was started □ Neck/Head immobilized

□ Placed on long spine board □ Oxygen given □ Transported to hospital by ambulance

□ Transported to hospital by LifeFlight □ Other: _____

Name of hospital you were transported to by Fire Rescue: _____

At the hospital the following were performed:

□ X-rays □ CT scan □ MRI □ Stitches □ Cast to my _____

□ Prescription medication □ Referred to Specialist □ Emergency Surgery

□ Hospitalized for: _____ Days □ Other: _____

□ I did not seek medical attention at the time of the accident

If medical treatment was refused or not deemed necessary, what did you do next?

□ I continued about my day □ I went to work □ I went to home □ I took myself to the hospital later

List any follow up doctor's appointments you made, their name, the date of the follow up appointments and any treatments rendered at these appointments: _____

_____

_____

Since the accident what pain symptoms are you currently feeling? _____

_____

The above symptoms are: □ Not changing □ Getting worse □ Getting better

Since the accident, what have you done to manage your symptoms?

□ Nothing □ Over the counter medication □ Prescription medication □ Hot/cold packs

□ Massages □ Other: _____

Patient Name: _____ *Patient #:* _____ *Date:* _____

IMPORTANT AKNOWLEDGEMENT BY PATIENT WHO HAS SIGNED A PERSONAL INJURY PROCEEDS ASSIGNMENT:

_____ Patient Initials

I understand this Assignment, and how it will affect my prospective settlement proceeds. I know that the Clinic is starting treatment in reliance that I understand the assignment. I received a copy of the Assignment.

_____ Patient Initials

I understand that I cannot cancel or terminate the assignment, and will not permit any attorney for me to attempt to do this.

_____ Patient Initials

I understand that this Clinic is entitled to its treatment fees first out of any and all settlement proceeds.

_____ Patient Initials

If I believe the prospective settlement from an insurance company will not be enough to cover my damages and this Clinic's treatment fees, I realize that I will owe any balance to this Clinic for my treatment. I can choose to continue treatment, or can consult with my chiropractic physician at this clinic about decreasing or terminating treatment prior to reaching Maximum Medical Improvement.

_____ Patient Initials

I state that I am not currently a debtor in a pending Chapter 7 or Chapter 13 Bankruptcy Proceeding.

_____ Patient Initials

I understand that this Assignment and the related documents that I have signed are for the purpose of protecting the Clinic's rights, and that they are not intended or designed to provide legal assistance to or for me.

*Patient Name:*_____ *Patient #:*_____ *Date:*_____

Payment for Treatment and Related Expenses

I have been injured. If my automobile insurance has medical payments coverage, I authorize this Clinic to bill this insurer and I will submit a claim with my insurer for this Clinic's treatment fees. Even if no other person is at fault for my injuries caused by an accident, I agree to sign this Clinic's Assignment and related documents, and will provide any information required by the Clinic. I realize that any money which I receive from my automobile insurer for this Clinic's treatment fees (including under or uninsured motorists coverage proceeds) must be immediately paid over to this Clinic.

If I believe that one or more persons are at fault for causing my injuries in an accident, I agree to sign this Clinic's Assignment and related documents, and will provide any information required by the Clinic.

I understand that my automobile insurer, or an insurer representing someone I believe to be at fault for causing my injuries, or that persons' attorney representing me in a claim for injuries, may request reports, copies of records, may require a physician from this Clinic to provide deposition testimony or testimony in court, or other information. I understand and agree that I am financially responsible to this Clinic to pay the Clinic's costs for these items, and that the Clinic may request payment in advance for some or all of these items, even if this Clinic's Assignment states otherwise.

I understand and agree that all of my records, including x-rays, are permanent records of this clinic. I authorize the release of any information relevant to my treatment, including information regarding treatment fees, to insurers and attorneys who are involved with my claim and their respective representatives. I understand that the Clinic may require any recipient of such information to comply with applicable federal, state, and/or local law prior to and during receipt of such information.

I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.
THIS DOCUMENT IS MADE A PART OF THE ASSIGNMENT.
I HAVE SIGNED IN FAVOR OF THE CLINIC.
I HAVE BEEN ADVISED THAT A COPY OF THIS DOCUMENT IS AVAILABLE UPON REQUEST.

_____ _____

Signature of patient Date

_____

Print or Type Patient Name

_____

Signature of Parent or Legal Guardian

Patient Name: _____ *Patient #:* _____ *Date:* _____

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident
□ Medical Savings Account & Flex Plans □ Other

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient Name: _____ *Patient #:* _____ *Date:* _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient or Legal Guardian

_____
Date Signed

==========

To be completed by doctor or staff:

Name and address of clinic/office:

Positive Chiropractic Solutions
9200 Navarre Parkway, Suite E
Navarre, FL 32566

Print name (s) doctor (s) treating this patient:

Amanda M. Williams, D.C.

Patient Name: _____ *Patient #:* _____ *Date:* _____

HIPAA Notice of Privacy Practices

Positive Chiropractic Solutions, PLLC
9200 Navarre Parkway, Suite E
Navarre, FL 32566

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our Privacy Officer, Dr. Amanda M. Williams, D.C. at (850) 939-2200.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date