Personal Information

First Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss | **MI:** | **Today's Date:** / /

Last Name:

Address: | **Date of Birth:** / / | **Age:**

City: | **State:** | **Zip:** | **Gender:** ☐ Male ☐ Female

Cell Phone #: ( ) - | **Home Phone #:** ( ) - | **E-mail Address:**

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name: | **Contact Phone #:** ( ) -

Emergency Contact *(if different from spouse)* | **Contact Phone #:** ( ) -

Employment Status: ☐ Full-Time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Student

Employer Name: | **Work Phone #:** ( ) -

Family Physician *(if applies)* **:** | **Contact Phone #:** ( ) -

Person Responsible for Bills *(if different from personal information)*

First Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss | **MI:** | **Today's Date:** / /

Last Name:

Address: | **Date of Birth:** / / | **Age:**

City: | **State:** | **Zip:** | **Gender:** ☐ Male ☐ Female

Cell Phone #: ( ) - | **Home Phone #:** ( ) - | **E-mail Address:**

Employer Name: | **Work Phone #:** ( ) -

Reason for Your Visit to Our Office

☐ Auto Accident ☐ Independent Personal Health Reasons ☐ Personal Accident (slip & fall)

How Did You Hear About Us

Friend Refered Me (please write down their name):

☐ Internet/Website ☐ Doctor Refered ☐ Insurance Agent Refered ☐ Lawyer Refered

Complaint History

Patient Name _____ **Date** _____

Current Health Complaint: ***(Give a brief, detailed description of the problem you are currently experiencing)***

When did this problem start (date)? | How did it start?

How often do you feel it? ☐ 0-25% of the time (intermittent), ☐ 26-50% of the time (occastional), ☐ 51-75% of the time (frequently), ☐ 76-100% of the time (constantly)

What does it feel like? *(Please check all that apply):*

☐ Achy ☐ Burning ☐ Congestion ☐ Cramping ☐ Crawling ☐ Dull ☐ Electric-like ☐ Fatigue ☐ Itchy ☐ Nagging ☐ Numb
☐ Pounding ☐ Pressure ☐ Pulling ☐ Sharp ☐ Shooting ☐ Sore ☐ Spasm ☐ Stabbing ☐ Stiff ☐ Stressed ☐ Tight ☐ Tingling
☐ Throbbing ☐ Weakness ☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric-like with motion

Does it radiate to anywhere? *(please describe)* :

On a Scale of 0 to 10 - where 0 is no pain and 10 is the worst pain ever - please circle the numbers that apply:
Level you feel the most: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the best: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the worst: 0 1 2 3 4 5 6 7 8 9 10

Does anything make it feel worse? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Twisting right ☐ Twisting left
☐ Climbing stairs ☐ Coughing ☐ Driving ☐ Exercising ☐ Kneeling ☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side
☐ Carrying ☐ Lifting ☐ Pushing ☐ Pulling ☐ Running ☐ Sleeping ☐ Sneezing ☐ Sitting ☐ Standing ☐ Straining ☐ Stretching
☐ Walking ☐ Work duties ☐ Feels worse in the A.M. ☐ Feels worse in the P.M. ☐ Nothing specific makes it feel worse
☐ Other *(please describe)* :

Does anything make it feel better? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Resting ☐ Sleeping
☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side ☐ Massage ☐ Moving around ☐ Sitting ☐ Standing ☐ Walking
☐ Stretching ☐ Icing the symptomatic area ☐ Heat on the symptomatic area ☐ OTC Medication ☐ Prescription medication
☐ Feels better in the A.M. ☐ Feels better in the P.M. ☐ Nothing specific makes it feel better
☐ Other *(please describe)* :

Have you received **previous treatment** for this condition? From who? ☐ Yes, ☐ No
☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other:

Did the treatment help?
☐ It improved ☐ Got Worse ☐ There was no change

Activites of Daily Living *(Please mark a number, as described below, for all the problems you are experiencing)*

0 = Not a Problem, 1 = Mild difficulty (can do it but with pain), 2 = Moderate difficulty (have pain and it really hurts), 3 = Significant difficulty (unable to perform without agonizing pain)

Hygiene: ___ Bathing ___ Showering ___ Washing your hair ___ Drying your hair ___ Combing your hair ___ Washing your face ___ Brushing your teeth
___ Using the toilet ___ Putting on make-up ___ Shaving your legs ___ Shaving your face

Self Care: ___ Cleaning dishes ___ Eating ___ Preparing meals ___ Putting on a shirt ___ Hooking your Bra ___ Putting on pants ___ Putting on shoes
___ Tying your shoes ___ Cleaning your home ___ Doing laundry ___ Making your bed ___ Getting normal, restful sleep at night
___ Participating in desired sexual activity

Work: ___ Concentrating ___ Using a keyboard ___ Writing ___ Performing work Duties

Activities: ___ Climbing ___ Driving ___ Golfing ___ Jogging ___ Personal hobbies ___ Playing sports ___ Running ___ Walking ___ Weightlifting
___ Exercising ___ Exercising upper body ___ Exercising lower body ___ Exercising arms ___ Exercising legs

Movement: ___ Carrying your purse ___ Carrying small objects ___ Carrying large objects ___ Climbing Stairs ___ Climbing inclines ___ Grasping objects
___ Lifting ___ Pushing ___ Pulling ___ Reaching ___ Reclining ___ Kneeling ___ Sitting ___ Standing
___ Bending forward ___ Bending Back ___ Bending/Leaning right ___ Bending/Leaning left ___ Twisting right ___ Twisting left
___ kneeling for long periods ___ Sitting for long periods ___ Standing for long periods ___ Walking for long periods

Other *(please describe)* **:**

Health History

ALL INFORMATION IS CONFIDENTIAL

Patient Name _____ **Date** _____

Circle "C" for Current problems or Mark the box with a check ☑ next to the conditions you've had in the past

General Health Conditions:

C ☐ Alcoholism C ☐ Allergies C ☐ Anemia C ☐ Anxiety C ☐ Bi-polar disorder C ☐ Cancer C ☐ Chicken pox
C ☐ Cold sores C ☐ Depression C ☐ Diabetes C ☐ Dizziness C ☐ Edema (Swelling) C ☐ Endometriosis C ☐ Epilepsy
C ☐ Fainting C ☐ Fatigue C ☐ Goiter C ☐ Headaches C ☐ Hepititis C ☐ Herpes C ☐ High cholesterol
C ☐ HIV/ AIDS C ☐ Malaria infection C ☐ Measles C ☐ Miscarrage C ☐ Multiple sclerosis C ☐ Mumps C ☐ Nervousness
C ☐ Osteoporosis C ☐ Pace maker C ☐ Polio C ☐ Rhumatic fever C ☐ Stroke C ☐ Tremors C ☐ Thyroid disease
C ☐ Tuberculosis C ☐ Unexplained weight loss C ☐ Unexplained weight gain

Muscle & Joint Conditions:

C ☐ Arthritis (Joint pain) C ☐ General muscle pain C ☐ Neck pain C ☐ Mid-back pain C ☐ Low-back pain C ☐ Shoulder pain C ☐ Elbow pain
C ☐ Wrist/Hand pain C ☐ Hip pain C ☐ Knee pain C ☐ Ankle pain C ☐ Foot pain C ☐ Bursitis C ☐ Gout

Skin Conditions:

C ☐ Boils C ☐ Bruise easliy C ☐ Dryness C ☐ Eczema C ☐ Hives C ☐ Itching C ☐ Jaundice C ☐ Rash C ☐ Shingles C ☐ Varicose veins

Eyes, Ears, Nose & Throat Conditions:

C ☐ Deafness C ☐ Ear aches C ☐ Eye pain C ☐ Gum disease C ☐ Hoarseness C ☐ Nasal obstruction C ☐ Nose bleeds
C ☐ Ringing in ears C ☐ Sinus infection C ☐ Sore throat C ☐ Tonsilitis C ☐ Vision problems

Respiratory Conditions:

C ☐ Asthma C ☐ Bronchitis C ☐ Chronic cough C ☐ COPD C ☐ Coughing up phlem C ☐ Emphysema C ☐ Pneumonia
C ☐ Spitting up blood C ☐ Wheezing C ☐ Pain with breathing C ☐ Shortness of Breath

Cardiovascular Conditions:

C ☐ Arteriosclerosis C ☐ Heart disease C ☐ Hypertension C ☐ Hypotension C ☐ Irregular pulse C ☐ Pain over heart C ☐ Palpatations
C ☐ Poor circulation C ☐ Bradycardia C ☐ Tachycardia C ☐ Swelling in ankles

Gastrointestinal Conditions:

C ☐ Abdominal pain C ☐ Appendicitis C ☐ Bloated abdomen C ☐ Black stool C ☐ Bloody stool C ☐ Celiac Disease C ☐ Cirrhosis of liver
C ☐ Colitis C ☐ Crohn's disease C ☐ Constipation C ☐ Diarrhea C ☐ Difficult digestion C ☐ Diverticulitis C ☐ Excess gas
C ☐ Gall stones C ☐ Gastric reflux C ☐ Hernia C ☐ Hemorrhoids C ☐ Intestinal worms C ☐ Irritable Bowel C ☐ Leaky Gut Syndrome
C ☐ Nausea C ☐ Painful defication C ☐ Poor appetite C ☐ Stomach pain C ☐ Vomiting C ☐ Ulcers

Genitourinary Conditions:

C ☐ Bladder infections C ☐ Blood in urine C ☐ Impotence C ☐ Kidney infection C ☐ Kidney stones C ☐ Stress incontinence
C ☐ Bed wetting C ☐ Decreased flow or force C ☐ Painful urination

Male Specifc:

Date of last prostate exam: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a prostate exam

Female Specifc:

Date of last PAP exam: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a PAP exam

Date of last Mamogram: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a Mamogram

Are you taking Birth Control medication? ☐ Yes ☐ No / If *Yes*, please indicate the name in the medication section on the next page

Are you Pregnant? ☐ Yes ☐ No / If *Yes*, how many months: _____

Menstrual Flow: ☐ Regular ☐ Regular with pain and/or camping ☐ Irregular ☐ Irregular with pain and/or camping

Patient Name _____ **Date** _____

Allergies *(please list all known allergies)* **:**

☐ Animal dander ☐ Animal hair ☐ Beef ☐ Corn ☐ Dairy ☐ Eggs ☐ Fish ☐ Fungus
☐ Latex ☐ Legumes ☐ Mold ☐ Nuts ☐ Peanuts ☐ Penicillin ☐ Pollen ☐ Ragweed
☐ Shellfish ☐ Soy ☐ Strawberries ☐ Wheat ☐ Other *(please describe)* :

Medication *(please list all medications that you are currently using)* **:**

Over-the-counter:
☐ Advil ☐ Alieve ☐ Acetaminophen ☐ Aspirin ☐ Ibuprophen ☐ Motrin ☐ Naproxen Sodium ☐ Tylenol

Prescribed Medication:
☐ Alendronate ☐ Chantix ☐ Crestor ☐ Cymbalta ☐ Darvocet ☐ Daytrana ☐ Estrogen ☐ Flexeril
☐ Hydrocodone ☐ Levoxyl ☐ Lipitor ☐ Morphine ☐ Norco ☐ Oxycontin ☐ Percocet
☐ Testosterone ☐ Ultram ☐ Valium ☐ Wellbutrin ☐ Zanaflex ☐ Zocor ☐ Zoloft

☐ Other *(please describe)* :

Vitamins, Minerals & Herbs *(please list all that you are currently using)* **:**

☐ Multivitamin ☐ Vitamin B ☐ Vitamin C ☐ Vitamin D ☐ Vitamin E

☐ Other *(please describe)* :

Surgeries & Hospitalization *(please list any surgeries and the years performed, the years you gave birth, any other reason for being hospitalized and the year)* **:**

Surgery: _____

_____

Births *(years)* : _____

Hospitalization: _____

_____

Injuries *(please list any previous auto accidents and the year, bone fractures and the year, sprains/strains and the year)* **:**

Injuries: _____

_____

Family History *(Please circle the family member "symbol" for any of the applicable diseases or illnesses)* **:**

F = Father / **M** = Mother / **B** = Brother / **S** = Sister / **PGF** = Paternal Grandfather / **PGM** = Paternal Grandmother / **MGF** = Maternal Grandfather / **MGM** = Maternal Grandmother

Alcoholism	F	M	B	S	PGF	PGM	MGF	MGM	Epilepsy	F	M	B	S	PGF	PGM	MGF	MGM
Anemia	F	M	B	S	PGF	PGM	MGF	MGM	Glaucoma	F	M	B	S	PGF	PGM	MGF	MGM
Arteriosclerosis	F	M	B	S	PGF	PGM	MGF	MGM	Heart disease	F	M	B	S	PGF	PGM	MGF	MGM
Arthritis	F	M	B	S	PGF	PGM	MGF	MGM	High blood presure	F	M	B	S	PGF	PGM	MGF	MGM
Asthma	F	M	B	S	PGF	PGM	MGF	MGM	High cholesterol	F	M	B	S	PGF	PGM	MGF	MGM
Bleed easily	F	M	B	S	PGF	PGM	MGF	MGM	Multiple Sclerosis	F	M	B	S	PGF	PGM	MGF	MGM
Cancer	F	M	B	S	PGF	PGM	MGF	MGM	Osteoporsis	F	M	B	S	PGF	PGM	MGF	MGM
Diabetes	F	M	B	S	PGF	PGM	MGF	MGM	Stroke	F	M	B	S	PGF	PGM	MGF	MGM
Emphysema	F	M	B	S	PGF	PGM	MGF	MGM	Thyroid disease	F	M	B	S	PGF	PGM	MGF	MGM

Personal Habbits *(please mark the appropriate options)* **:**

Alcohol	☐ Don't drink it	☐ 1-2 times per month	☐ drink 1-3 per week	☐ drink 1 per day	☐ drink 2 or more per day
Coffee	☐ Don't drink it	☐ drink 1-4 cups per week	☐ drink 1-3 cups per day	☐ drink 3 or more cups per day	
Tobacco	☐ Don't use it	☐ use light amounts	☐ use moderate amounts	☐ use heavy amounts	
Sleep	☐ Don't get regular sleep	☐ sleep 4-6 hours per night	☐ sleep 6-7 hours per night	☐ sleep 8 or more hours per night	
Soda	☐ Don't drink it	☐ drink 1-4 per week	☐ drink 1-2 per day	☐ drink 2-4 a day	☐ drink 4 or more a day
Water	☐ Don't drink it	☐ drink 1-3 cups per day	☐ drink 3-6 per day	☐ drink 6 or more cups a day	
Sugar	☐ Don't eat it	☐ eat light amounts	☐ eat moderat amounts	☐ eat heavy amounts	
Exercise	☐ Don't exercise	☐ engage in light exercise every week	☐ engage in moderate exercise every week	☐ engage in heavy exercise every week	

INFORMED CONSENT

(Please Read Carefully Before Signing.)

As will all things physical, when you engage in the treatment of soft (muscles, ligaments, etc.) and osseous (bone) tissues, there are risks in making changes to those tissues since they have been in a state of dysfunction for an undetermined amount of time. At Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic, we strive to provide the greatest physical health care available. Our methods and techniques allow us greater flexibility in our treatments and minimize the risks that can be found in traditional healthcare facilities. However, there are always risks in any treatment you decide to receive. This document outlines the possible risks of the type of care that we provide in this office. Please read all the information in this document before signing and accepting care.

- **The chiropractic adjustment:**
  The doctor will use his hands or a mechanical adjusting instrument, upon your body, in such a way, as to move your joints when necessary. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel or sense a movement of the joint. It is not uncommon to feel some stiffness and/or soreness in the adjusted areas following the first few days of treatment.

- **The material risks inherent in chiropractic adjustment:**
  There are certain complications which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and/or separations and/or rib fractures. In rare instances, some types of manipulation of the neck have been associated with injuries to the arteries (known as vertebral artery dissection) in the neck leading to or contributing to serious health complications including (but not limited to) stroke.

- **The probability of risks occurring:**
  Receiving a fracture from treatment is an extremely rare occurrence and generally results from some underlying pathological weakness of the bones. The different causes of stroke have been the subject of tremendous disagreement within the medical community for decades. One prominent authority claims that there is at most a one-in-a-million chance of such an outcome while utilizing the chiropractic adjustment in the cervical spine. As a policy, to reduce your risk, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The possibility of having the other complications that are list above in the *material risks section* also generally described as occurring "rarely."

- **Ancillary (Modality) treatments:**
  In addition to chiropractic adjustments, we use the following treatments which have been listed with their known risks:
  - ***Needle acupuncture*** - infection is rare but possible. We use single use, sterile needles to reduce this risk.
  - ***Electrical stimulation*** - Skin burns and soft tissue irritation.
  - ***Infrared heat (moxa) therapy*** - Skin burns.
  - ***Physiotherapy*** - Used to rehabilitate fascia, muscles, ligaments and nerves. Possible side effects are:
    - Muscle strain and/or reinjury of presented complaint(s)
    - Ligamentous strain, sprain or reinjury
    - Possible reinjury of presented complaint(s)
  - ***Manual therapy*** - Used to release muscle tension, skeletal subluxation and toxic metabolites. This can cause muscle stiffness and aches as well as headaches and/or **bruising of the soft tissues**. Drinking plenty of water should aid in a quick recovery if these symptoms arise.
  - ***Neuromuscular Therapy*** - Findings are similar to Manual Therapy.

- **The availability and nature of other treatment options:**
  Other treatment options for your condition include:
  - Self-administered, over-the-counter analgesics and rest or exercise, etc.
  - Prescription drugs such as anti-inflammatory, muscle relaxants and painkillers recommended and provided by your MD.
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**
  - Overuse of over-the-counter medications can produce undesirable side effects. If complete recovery is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Available (online) literature describes the highly undesirable effects from long term use of over-the-counter medicines.
  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors. Additionally, there is no guarantee of outcome with surgery.

- **The risks and dangers attendant to remaining untreated:**
  Remaining untreated allows the formation of adhesions, a continual increase of soft tissue inflammation and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

- **Treatment Outcome Possibilities:**
  The treatments provided in this clinic have proven to be effective in relieving a variety of illnesses and health problems. The outcome of treatments provided have the following possibilities: *the symptoms or illness you have sought care for may improve, may remain unchanged, or have the possibility of getting worse.* We strive to ensure that your care is complete and that you will be satisfied with your outcome.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED ABOVE.
By signing this informed consent, you agree that you have read ALL (in its entirety) or that someone has read to you ALL (in its entirety) the above explanation(s) of the nature of any treatments provided and possible risks with undergoing and/or receiving chiropractic treatment and modality treatments. By signing below, you are stating that you also understand the inherent risks of refusing chiropractic treatment and modality treatments provided by the staff and/or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic.
By signing below, I state that I have weighed the risks involved in undergoing and/or receiving treatment and assume the risk in receiving any and all chiropractic treatment and/or all modality therapies and I have decided it is in my best interest to undergo and/or receive any and/or all said treatment as well as any or all other treatments and services offered and provided by the staff and or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic.
Having been informed of the risks, I hereby give my consent and assume any and/or all the risks of receiving any and/or all treatment deemed necessary the staff and or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic for any reason. I understand that if I have any questions regarding treatment and/or services, I may ask the doctor and/or staff at any time for an explanation for reasons and purposes of treatment or services provided.

_____ _____
Patient Printed Name Date

_____
Patient Signature

_____
(Signature of Parent or Guardian or Responsible Party)

HIPPA PRIVACY NOTIFICATION & PRACTICE REQUIREMENTS

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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or mental health or condition, and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI 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 purposes of providing health care services to you, 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 PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI 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 PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain prior approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to

sign your name and indicate your physician. We may also call you by name in the waiting room when your physician in ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroner, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. 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, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction on your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your dare 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 the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI 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 obtain a paper

copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this Notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints. You may complain to us or 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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This Notice was published and becomes effective on/before April 1, 2019.

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 PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Clicking "Agree" below is only acknowledgment that you have received this Notice of our Privacy Practices.

PATIENT ACKNOWLEDGEMENT:
By subscribing my name below, I acknowledge having read the Notice; I understand it and agree to its terms.

Signature of Patient, Parent/Guardian or Responsible Party	**Date**