West County Spine & Joint
Chiropractic Clinic

Patient's Name: _____ **Height:**___'___" **Weight:** _____lbs **Date:** _____

Family Physician/Internist: _____ _____Phone: _____
May we share your information in our patient records with your above listed physician for integrated care? ☐ YES ☐ NO

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you had previous Chiropractic Care: ☐ Yes ☐ No *If yes, for what problem?* _____
Doctor's Name: _____ Phone/City/State: _____

Patient Social Security #: _____-____-_____ **Social Security # of Primary Insured:** _____-____-_____

Occupation: _____ Employer: _____
Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed

Dear Patient: ***Please complete this form and questionnaire. Your answers will help us determine if chiropractic care can help and where to focus your examination. If we do not sincerely believe your condition will respond well, we will not accept your case.***

In general, would you say your health is (check one): ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

1. Have you ever had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when? _____
2. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No
   If yes, when? _____

Social History:
Recreational Activities/Hobbies: _____

Yes	No	
☐	☐	Do you exercise? _____ times/week
☐	☐	Do you eat a balanced diet? If no, explain: _____
☐	☐	Do you drink enough water daily? How much water do you drink per day? _____oz/day
☐	☐	Do you consume caffeine? How much? _____oz/day
☐	☐	Do you get adequate sleep? How many hours per night:_____
☐	☐	Is work stressful to you? If yes, explain: _____
☐	☐	Is family life stressful to you? If yes, explain: _____

PLEASE ANSWER ALL QUESTIONS BELOW

Please describe **what** caused the pain & when it started: _____

What makes it worse? _____

What makes it better? _____

What activities can you not do because of your problem? _____

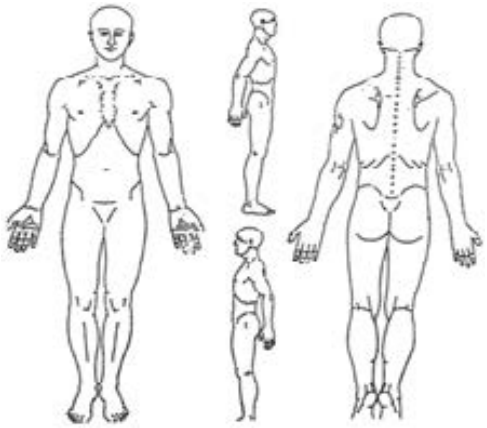
Does the pain interfere with your sleep? ☑ Yes ☐ No Is Pain worse in the ☐ Morning ☐ Afternoon ☐ Night

Have you detected a possible relationship between your current pain and any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder Problems ☐ Digestion ☐ Cardiac/respiratory ☐ Other: _____

FEMALES: Are you currently pregnant? ☐ YES ☐ NO Do you have a regular monthly cycle? ☐ YES ☐ NO ☐ MENOPAUSE

Please mark areas of pain using these codes:
+++ Burning
Dull/Ache
*** Numbness/Tingling
ooo Sharp/Stabbing



On a scale of 0-10, how bad is your pain?
_____/10

What are your goals for treatment? Are you training for a particular event/race?Anything else you'd like the doctors to know?

REVIEW OF SYSTEMS **NAME:** _____

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowniness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps/Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Conciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

ALLERGIC/UMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tary Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy/Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC/LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

Patient Questionnaire and Informed Consent for Soft Tissue Treatments

Please answer the following questions. Read the statements concerning Graston Technique® and other soft tissue treatments (such as Cupping, Positional Release, Normatec Compression System and Kinesiotape) your doctor may reccomend as beneficial and sign below. If you have any questions, please speak with your doctor.

1. Do you bruise easily? ☐ Yes ☐ No
2. Do you bleed for a long period of time after you cut yourself? ☐ Yes ☐ No
3. Are you taking blood thinners or anticoagulants? ☐ Yes ☐ No
4. Do you take aspirin on a regular basis? ☐ Yes ☐ No
5. Do you take cortisone on a regular basis? ☐ Yes ☐ No
6. Have you ever had inflamed veins or blood clots? ☐ Yes ☐ No
7. Do you have surgical implants in your body? ☐ Yes ☐ No
8. Do you have diabetes or kidney disease? ☐ Yes ☐ No
9. Do you currently have any infections? ☐ Yes ☐ No
10. Do you have uncontrolled high blood pressure? ☐ Yes ☐ No

Graston Technique® (GT) is a system of instrument-assisted soft tissue mobilization that utilizes a set of six instruments that aid the GT trained clinician in detecting treatable soft tissue lesions. The GT instruments consist of six stainless steel instruments of various sizes and contours. GT is a form of treatment used to "break up" or "soften" scar tissue, thus allowing for the return of normal function in the area being treated.

Graston Technique® may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

Graston Technique® is designed to minimize discomfort; however the above reactions are normal, and in some instances desirable and unavoidable.

The Graston Technique® protocol has several basic components. Your clinician will determine the protocol for you which may include the following components that are selected after a comprehensive evaluation has been performed.

1. Warm up of the treatment area.
2. Graston Technique® Instrument Assisted Soft-Tissue Treatment.
3. Therapeutic exercise to include appropriate stretching and/or strengthening which will be performed before, during or after your GT treatment.
4. Ice therapy.

All components of Graston Technique® have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print your name: _____ Date: _____

Your signature: _____

OUR MISSION STATEMENT

To inspire and empower families in our community to lead healthy, active and pain free lifestyles. We do this by teaching you to have faith in your body's natural ability to heal and be healthy. We aspire to serve as many people as possible with natural healthcare so that our community can realize its full potential.

INFORMED CONSENT

I understand this Facility, its doctors & staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change occur.

I further understand that in the practice of medicine, chiropractic, massage therapy, weight loss counseling and physical therapy there are some risks including but not limited to fractures, disc injuries, strokes, dislocations, sprain-strains, drug interactions & reactions and/or other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or other complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probably consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of this Facility.

ASSIGNMENT OF BENEFITS- AUTHORIZATION AND LEIN

I, the assignee, being the patient or legal guardian for the said minor listed below, do herby irrevocable authorize, direct, assign and give full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any and all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee, further authorize any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS- CREDIT POLICIES- PAYMENT TERMS & CONDTIONS

1. As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage, and liability. Our Facility and staff are not responsible for what third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.
2. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in additional filing medical report charge which you are responsible to pay.
3. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered. A credit card will be kept on file and charged at the time of service. That card will also be charged for any outstanding balances over 30 days.
4. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
5. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee if fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
6. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services without filing a claim with a health insurance company and pays in full the day services are rendered. The "TOS" discount is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchase, vitamins, supplements, ointments, acupuncture treatments, weight loss programs and massage therapy.
7. A service charge is computed by a "periodic rate" of 1 ½% per month- 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's.
8. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.

I understand & agree to the above statements. Any questions I have had regarding the above have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

_____ _____

Signature **Date**

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. A copy of the HIPPA Notice is on the following page of this document for review.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

I furthermore hereby authorize West County Spine & Joint to release my medical information to the following person(s)/entities:

_____
_____
_____
_____

WEST COUNTY SPINE & JOINT
CHIROPRACTIC CLINIC
WestCoSpineAndJoint.com

Notice of Patient Rights & Privacy Policy Under Federal Privacy Laws (HIPAA)

The Health Insurance Portability and Accountability Act of 2013, commonly referred to as HIPAA, requires this office to implement and maintain numerous policies and safeguards which insures a patients' secure health information (PHI) remains secure and only used in a manner consistent with HIPAA and similar laws. 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.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by federal law 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 protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.westcospineandjoint.com, or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, 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. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information 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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. 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.
  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.
- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.
  For example, we may disclose your protected health information to chiropractic interns or preceptors 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 doctor. Communications between you and the doctor or her assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We do have open therapy areas. You may request a private treatment/therapy room if you wish, and it will be provided to you. We will share your protected health

information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name, address, and email address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only with Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **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 et. seq.

Notice Distribution

For every patient of our office, we must have delivered a privacy practice notice to patients starting on April 14, 2003 as follows:

- Not later than the first service encounter by personal deliver, by automatic and contemporaneous electronic response, or by prompt mailing.
- By posting the notice at each service site in a clear and prominent place where people seeking service may reasonable be expected to be able to read the notice; and
- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates.

Our office must make a good faith effort to obtain written acknowledgement from patients of receipt of the privacy practices notice.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.
  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied 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. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.
- **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 have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office. You may also request that any part of your protected health 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 be in writing and state the specific restriction requested and to whom you want the restriction to apply.
  Your provider is not required to agree to a restriction that you may request. If the doctor 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. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in said, please discuss any restriction you wish to request with your doctor. You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the bottom of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.
- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Officer if you have questions about amending your medical record.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of

Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- **You have the right to be notified by our office of any breech of privacy of your Protected Health Information.**
- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times**. Please note private rooms are always available, upon request, for discussing your private health information. Let any office staff member know and we will accommodate the request.
- **We may send information to you via email.** You may request to not receive communication via email and use our secure patient portal. Please make this request in writing.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have accepted this notice electronically.

C. 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.

To file a complaint, you may go to: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf*

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Dr. Lauren Hendrix. You may contact our Privacy Officer, or any staff member, at the following phone number 636-394-2225 for further information about the complaint process.

This notice was published and becomes effective on January 15, 2018.