

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient

## 3 PHONE NUMBERS

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## 5 PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

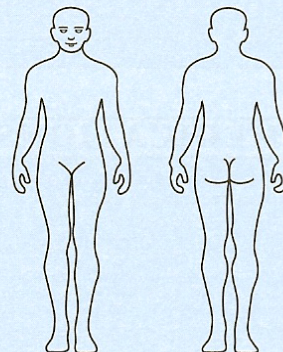
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# 6

## HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

|                     |  |                     |  |                      |  |                              |  |
|---------------------|--|---------------------|--|----------------------|--|------------------------------|--|
| AIDS/HIV            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____                  |  |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Chicken Pox         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
|                     |  |                     |  | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |

### EXERCISE

- None
- Moderate
- Daily
- Heavy

### WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

### HABITS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_
- Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

| Injuries/Surgeries you have had | Description | Date  |
|---------------------------------|-------------|-------|
| Falls                           | _____       | _____ |
| Head Injuries                   | _____       | _____ |
| Broken Bones                    | _____       | _____ |
| Dislocations                    | _____       | _____ |
| Surgeries                       | _____       | _____ |

# 7

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

|                             |       |       |
|-----------------------------|-------|-------|
| _____                       | _____ | _____ |
| _____                       | _____ | _____ |
| _____                       | _____ | _____ |
| Pharmacy Name _____         | _____ | _____ |
| Pharmacy Phone (____) _____ | _____ | _____ |

**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 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 doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand and I am informed that in the practice of chiropractic, as in the practice of medicine, 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 or explain all risks and complications. I wish to rely on the doctor to exercise judgment based on the facts known at the time of service based on my best interests, during the course of treatment.

I have read 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 consent to this 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:

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient's Name (print) Patient's Signature

To be completed by patients representative If patient is a minor or incapacitated:

\_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian's Name Parent or Legal Guardian's Signature

**Female Patient's Only:**

This is to certify that to the best of my knowledge, I am **NOT** pregnant and that Dr. Kelly Lucas has my permission to take x-rays. (Please enter the first day of your last period): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient's Signature

This is to certify that to the best of my knowledge, I **AM** pregnant and that Dr. Kelly Lucas **DOES NOT** have my permission to take x-rays. Please enter how many months/weeks pregnant you are: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_  
Estimated Due Date Patient's Signature

Name and Address of Clinic:

Coast Rehabilitation  
1500 E. Katella Ave., Ste. G  
Orange, CA 92867

Doctors Treating this Patient:

•Kelly K. Lucas, D.C.  
Homa Bakhtar, D.C  
John R. Kole, D.C

# Financial Agreement

We would like you to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled. All patient portions of charges for treatment in this office are due and payable at the time the service is performed. The first visit is to be paid in full at the time of service for all patients with or without insurance benefits (except workman's compensation or personal injury). **Please Initial where it applies.**

## Payment Plans

\_\_\_\_\_ **PRIVATE PAY:** I agree to pay for each visit at the time of service or I will agree to prepay for visits on a weekly/monthly basis. \*Discounts are offered with prepaid visit plans. \*

\_\_\_\_\_ **PRIVATE/GROUP INSURANCE:** I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and my co-insurance amount at the time of service or prepay on a weekly/monthly basis. I will pay for the first visit in full at the time of service. That payment will be applied toward my yearly deductible, co-insurance amount or will be fully refunded if my insurance pays 100%. \* As a courtesy our staff will verify your health insurance benefits but we cannot guarantee payment or the accuracy of benefits quoted.\*

\_\_\_\_\_ **MEDICARE:** I understand that my Medicare insurance policy only covers 80% of allowed charges for spinal manipulation procedures performed by a chiropractor. Any and all other charges are considered not covered by Medicare. I agree to be personally responsible for payment of my deductible amount, my co-payment amount for covered services and for all non-covered services such as: x-rays, vitamins/supplements, pillows or supports.

\_\_\_\_\_ **PERSONAL INJURY:** I agree to allow Coast Rehabilitation to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no medical coverage is available with my auto insurance or if I exhaust my benefits, that I will be personally responsible to pay for all charges incurred. If medical coverage is not available on my auto insurance policy my private health insurance may be billed.

**ATTORNEY LIEN:** I understand that Coast Rehabilitation has agreed to carry the balance of any unpaid charges on a lien with my attorney. I further understand that if I change attorneys or release this attorney prior to the settlement of my claim this agreement is void and I agree to pay the full balance due immediately.

**3<sup>rd</sup> PARTY CLAIM (no attorney):** I understand that I am making a claim against a 3<sup>rd</sup> party insurance policy and that this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree that I am personally responsible to pay charges incurred on a daily/weekly/monthly basis or at the time of settlement of my claim.

\_\_\_\_\_ **WORKMAN'S COMPENSATION:** I understand that I am filing a worker's compensation claim. I also understand that if I do not follow the doctor's recommendations for care or if I miss appointments my claim may be denied. If my claim is denied because of my failure to follow the doctor's recommendation for treatment or because I miss appointments I understand I will be responsible and liable for the balance of the bill.

\_\_\_\_\_ **MISSED APPOINTMENT FEE:** I understand and Agree to pay a fee of \$25.00 upon a missed appointment that I did not cancelled within a 24 hr notice. I understand that this fee includes a massage appointment as well, if I did not cancel within the 24 hr period.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I have read and agree to the above:

\_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature

To be completed by patient's representative If patient is a minor or incapacitated:

\_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian's Signature

**Dr. Kelly K. Lucas, DC**  
1500 East Katella Ave. Unit G  
Orange, CA 92867  
714-639-7654

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## HIPPAA NOTICE OF PRIVACY PRACTICES

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**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 HEALTHCARE OPERATIONS (TPO) AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW. IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION. "PROTECTED HEALTH INFORMATION" IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC INFORMATION, THAT MAY IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT, AND FUTURE PHYSICAL OR METNTAL HEALTH OR CONDITION AND RELATED HEALTH CARE SERVICES.

### **1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

YOUR PROTECTED HEALTH INFORMATION MAY BE USED AN D DISCLOSED BY YOUR PHYSICIAN, OUR OFFICE STAFF AND OTHERS OUTSIDE OF OUR OFFICE THAT ARE INVOLVED IN YOUR CARE AND TREATMENT FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES TO YOU, TO PAY YOUR HEALTH CARE BILLS, TO SUPPORT THE OPERATION OF THE PHYSICIAN'S PRACTICE, AND ANY OTHER USE REQUIRED BY LAW.

**TREATMENT:** WE WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE, COORDINATE, OR AMNAGE YOUR HEALTH CARE AND RELATED SERVICES. THIS INCLUDES THE COORDINATION OR MANAGEMENT OF YOUR HEALTH CARE WITH A THIRD PARTY. FOR EXAMPLE, WE WOULD DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY TO HOME HEALTH AGENCY THAT PROVIDES CARE TO 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.

**PAYMENT:** YOUR PROTECTED HEALTH INFORMATION 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 PROTECTED HEALTH INFORMATION BE DISCLOSED TO THE HEALTH PLAN TO BE OBTAIN APPROVAL FOR THE HOSPITAL ADMISSION.

**HEALTHCARE OPERATIONS:** WE MAY USE OR DISCLOSE, AS NEEDED, YOUR PROTECTED HEALTH INFORMATION IN ORDER TO SUPPORT THE BUISNESS ACTIVITIES OF YOUR PHYSICIAN'S PRACTICE. THESE ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, QUALITY ASSESSMENT ACTIVITIES, EMPLOYEE REVIEW ACTIVITIES, AND TRAINING OF MEDICAL STUDENTS, LICENSING, AND CONDUCTING OR ARRANGING FOR THE BUISNESS ACTIVITIES. FOR EXAMPLE, WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION 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 ANME IN THE WAITING ROOM WHEN YOUR PHYSICIAN 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 MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION. THESE SITUATIONS INCLUDE: AS REQUIRED BY LA, PUBLIC HEALTH ISSUES AS REQUIRED BY LAW, COMMUNICABLE DISEASES: HEALTH OVERSIGHT: ABUSE OR NEGLECT: FOOD AND DRUG ADMINISTRATION REQUIREMENTS: LEGAL PROCEEDINGS: LAW ENFORCEMENT: CORONERS, FUNERAL DIRECTORS, 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 PROTECTED HEALTH INFORMATION

**YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION.** 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 PROTECTED HEALTH INFORMATION THAT IS SUBJECT TO LAW THAT PROHIBITS ACCESS TO PROTECT HEALTH INFORMATION.

**YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION.** THIS MEANS YOU MAY ASK US NOT TO USE OR DISCLOSE ANY PART OF YOUR PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR 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 STATE THE SPECIFIC RESTRICTION REQUESTED AND TO WHOM YOU WANT THE RESTRICTION TO APPLY.

YOUR PHYSICIAN IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST. IF PHYSICIAN BELIEVES IT IS IN YOUR BEST INTEREST TO PERMIT USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION, YOUR PROTECTED HEALTH INFORMATION, YOUR PROTECTED HEALTH INFORMATION WILL NOT BE RESTRICTED. YOU THEN HAVE THE RIGHT TO USE ANOTHER HEALTHCARE PROFESSIONAL.

**YOU MAY 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 PROTECTED HEALTH INFORMATION.** IF WE DENY YOUR REQUEST FOR AMENDMENT, YOU HAVE THE RIGHT TO FILE A STATEMENT OF DISAGREEMENT WITH US AND WE MAY PREPARE A REBUTTAL TO YOUR STATEMENT AND WILL PROVIDE YOU WITH A COPY OF ANY SUCH REBUTTAL.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE 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 YOUR PRIVACY RIGHTS HAS 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/ OR BEFORE APRIL 14, 2003**

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH, THIS NOTICE OF YOUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECT HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLAINT OFFICER IN PERSON OR BY PHONE AT OUR MAIN PHONE NUMBER.

SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES

PRINTED PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_