HEALTH QUESTIONNAIRE

Chart # _____ Date _____

A. Patient Information

First Name: _____ Last Name: _____ M.I.: _____

Address: _____ City, State, Zip: _____ Home phone #: _____

Email Address: _____ Cell phone #: _____

Sex: Male ____ Date of birth: _____ Age: _____ S.S.#: _____ D.L. #: _____

Female ____ Weight _____ Height _____

Occupation: _____ Employed by: _____ Work phone #: _____

Work address: _____ City, State, Zip: _____

Marital status single _____ married _____ widowed _____ divorced _____ other _____

Patient resides with: lives alone _____ spouse _____ parents _____ children _____

Children: yes ____ no ____ How many? _____

Spouse's name: _____ Spouse's phone #: _____

Spouse's Date of Birth: _____ SS #: _____ Spouse's employer/occupation: _____

Race: Caucasian _____ Black _____ Hispanic _____ Asian _____ American Indian _____ Other _____

Who referred you to our office? _____

Emergency Contact: _____ Phone #: _____

B. Review of Systems – Do you currently have any of the following?

1. Skin
   - ____ rash
   - ____ redness
   - ____ itching
   - ____ hair changes
   - ____ normal
   - ____ bruise easily
   - ____ dryness
   - ____ nail changes
   - ____ other

2. Nervous System
   - ____ paralysis
   - ____ dizziness
   - ____ headache
   - ____ tremors
   - ____ seizures
   - ____ weakness
   - ____ normal
   - ____ loss of consciousness
   - ____ memory loss
   - ____ anxiety
   - ____ depression
   - ____ mood swings
   - ____ other

3. Special Senses
   - ____ vision problems
   - ____ hearing loss
   - ____ loss of balance
   - ____ loss of taste
   - ____ other
   - ____ normal
   - ____ ringing ears
   - ____ loss of touch sensation
   - ____ sinus problem
   - ____ loss of smell

4. Reproductive
   - Male only:
     - ____ testical pain
     - ____ prostate problems
     - ____ infertility
     - ____ impotence
     - ____ other
   - ____ normal
   - Female only:
     - ____ painful menstruation
     - ____ breast lump/mass
     - ____ breast dimpling/discharge
     - ____ abnormal vaginal bleeding
     - ____ abnormal periods
     - ____ other

5. Cardiovascular\Pulmonary
   - ____ chest pain
   - ____ palpitations
   - ____ coughing
   - ____ wheezing
   - ____ murmur
   - ____ normal
   - ____ shortness of breath
   - ____ coughing up blood
   - ____ swollen extremities
   - ____ other

6. Digestive
   - ____ abdominal pain
   - ____ nausea
   - ____ vomiting
   - ____ constipation
   - ____ normal
   - ____ diarrhea
   - ____ hemorrhoids
   - ____ ulcer
   - ____ other

7. Urinary
   - ____ painful urination
   - ____ frequent urination
   - ____ bladder infections
   - ____ normal
   - ____ inability to hold urine
   - ____ kidney stones
   - ____ other

Doctor's Notes

_____

_____

_____

_____

C. Complaints

1.

	Right side	Left side	Pain	Pain level 0-10 0-good 10-worst	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	DOCTOR'S NOTES
Head											
Neck											
Upper Back											
Mid Back											
Shoulder											
Arm											
Forearm											
Wrist											
Hand											
Ribs											
Lower Back											
Buttock											
Hip											
Upper Leg											
Knee											
Lower Leg											
Ankle											
Foot											

2. When did your symptoms start? _____
3. Radiation/spread/referral of pain Y____ N____
4. How often do your symptoms occur?
   Intermittent ___ Occasional ___ Frequent ___ Constant ___
5. Are you getting? Better ___ Worse ___ Same ___
6. Have you had this condition before? Y____ N____
7. Are your complaints aggravated by?
   coughing ___ lifting ___ walking ___
   sneezing ___ bending ___ reaching ___
   straining at stool ___ sitting ___ other ___
   neck movement ___ standing ___
8. Are your complaints relieved by?
   nothing ___ standing ___ lying down ___
   heat ___ ice ___ stretching ___
   sitting ___ exercise ___ other ___
9. Since your symptoms began have you had a change in bodily functions? Y____ N____
   balance ___ gait ___ weakness ___
   coughing ___ sexual ___ coordination ___
   menstrual ___ vision ___ hearing ___
   urination ___ grip ___ sneezing ___
   bowel habits ___ sleep ___ weight ___
   breathing ___ swallowing ___ other ___
10. Have you had care for this condition? Yes____ No____
    List Doctors, treatments and dates _____
11. Have you had changes in activity of daily living?
    Yes____ No____

D. Social History

1. Do you sleep on: back ___ stomach ___ side L/R ___
   How well? _____
2. Do you exercise on a regular basis? Y___ N___
   How? _____
3. How do you spend your spare time (hobbies, etc.)?
   _____
4. Do you use: caffeine ___ tobacco ___
   alcohol ___ recreational drugs ___
5. Your diet is: balanced ___ fair ___ poor ___
   excessive ___ restricted ___

E. Family History

1. Are there any diseases or conditions that are common among your family members (inherited diseases or conditions)?
   _____

F. Work History

1. Number of jobs: 1___ 2___ 3___ Shift: 1___ 2___ 3___
2. full time ___ part time ___ temp ___ unemployed ___
   retired ___ student ___ homemaker ___
   disabled ___ partially ___ completely ___
3. Work week: hours per day ___ days per week ___
4. Do your present complaints affect the number of hours you work per day? Y___ N___
5. Length of time at present occupation:
   Years ___ Months ___
6. Type of work: professional ___ physical labor ___ clerical ___

G. Medical History

1. Have you been to a chiropractor: Y___ N___
2. Do you have a family physician: Y___ N___
   Date of last exam: _____
   Doctor name and address _____
   _____
3. Have you been hospitalized in the past? Y___ N___
   Date and reason: _____
   _____
4. Do you have any drug allergies? Y___ N___
5. Are you currently taking any drugs? Y___ N___
   ___ anti-inflammatory ___ antibiotics
   ___ muscle relaxants ___ birth control
   ___ pain pills ___ hormones
   ___ tranquilizers ___ blood pressure
   List any and for what conditions:
   _____
   _____

DOCTOR'S NOTES

6. WOMEN ONLY:

To your knowledge are you pregnant? Y ____ N ____

Last OB-GYN exam: _____

Dr. name: _____

7. Do you currently have or previously had any of the following?

____ allergies	____ arthritis
____ asthma	____ broken bone/fracture
____ cancer	____ diabetes
____ dislocated joints	____ AIDS
____ HIV	____ epilepsy
____ high blood pressure	____ hardening of arteries
____ herniated disc	____ kidney trouble
____ heart trouble	____ joint replacement
____ multiple sclerosis	____ osteoporosis
____ polio	____ prostate trouble
____ pacemaker	____ mental/emotional
____ STD	____ scoliosis
____ stroke	____ thyroid
____ surgical implants	

DOCTOR'S NOTES

8. Any other conditions or information you would like us to know?

How will you be paying today? Check ____ Cash ____ Credit Card ____ Other ____

Full payment is due at time of service. We accept cash, checks, Visa, MasterCard, Discover, American Express, and Care Credit. We will be glad to file health insurance, med pay claims, third party insurance, or Worker's Compensation claims. We accept insurance assignment. You will be responsible for paying your part of the care at the time of service. Our office does not guarantee that any form of insurance will pay. The patient is ultimately responsible for all charges incurred.

Patient Signature: _____ Date: _____

Authorization to Release Records to Patient's Insurance Carrier:

Patient Signature: _____ Date: _____

Chiropractic Care Clinic – YEAR 2020
Electronic Health Records Intake Form Chart#_____

First Name:_____ MI_____ Last Name:_____

DOB:_____ Gender: Male [ ] Female [ ] Preferred Language:_____

Sign up for Text reminders? Yes [ ] No [ ] Already Have [ ] Cell phone number_____

E-mail: _____

Emergency Contact/Relation:_____Phone#:_____

Smoking Status: Never Smoked [ ] Every Day Smoker [ ] Occasional Smoker [ ] Former Smoker [ ]

Smoking Start Date (Optional):_____

Race: American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] White (Caucasian) [ ]
Native Hawaiian or Pacific Islander [ ] Decline to Answer [ ] Other [ ]_____

Ethnicity: Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to Answer [ ]

Do you have any Medicine or Food or Environmental Allergies? Use back of form if necessary.

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Are you currently taking any medications? (For example, Lasix 20mg once daily) Use back of form if necessary

Medicine Dosage Frequency

_____

_____

_____

Family Medical History: (F-Father, M-Mother, B-Brother, S-Sister, or C-Child)

Heart Disease:_____ High Blood Pressure:_____ Diabetes:_____ Cancer:_____

Kidney Disease:_____ Lung Disease:_____ Other:_____

Existing Pts. Only – Address, Phone #, or Insurance Change:_____

Height:_____ Weight:_____

[ ] I choose to allow CCC to register clinical summary and set up my Patient Portal account.

Patient Signature:_____ Date:_____

For Office Use Only –

*Blood Pressure:*_____/_____ *Pulse*_____ *Dr.Kamerman*_____ *Dr.Ward*_____

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (___Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

LOW BACK PAIN DISABILITY QUESTIONNAIRE
(ROLAND-MORRIS)

Name _____ Number _____ Date _____

SCORE: _____

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try and get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I stand up only for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back pain.
- ☐ I have trouble putting on my socks (or stockings) because of pain in my back.
- ☐ I sleep less well because of my back.
- ☐ Because of back pain, I get dressed with help from someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back pain, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Reference: Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low-Back Pain. Spine 1983; 8(2): 141-144

Chiropractic Care Clinic
Statement of Financial Responsibility

Payment for services rendered is expected at time of service. This includes all co-pays and deductibles. We accept cash, checks, VISA, MasterCard, Discover, American Express, and Care Credit. We will be glad to file health insurance for companies that we are in network with. We will also file Worker's Compensation claims.

OUR OFFICE DOES NOT GUARANTEE THAT ANY FORM OF INSURANCE WILL PAY.
THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED.

I have read and understand this policy:

_____ _____

Signature Date

Cancellation Policy

The main goal of Chiropractic Care Clinic is to provide the best possible care to our patients.

As of Monday, December 14, 2009, we have implemented a new policy concerning missed or cancelled appointments. Appointment cancellations will require a 24 hour advance notice.

Patients with scheduled appointments that are not cancelled within 24 hours will be charged a fee of $25.00

This will allow us to take care of other patient needs that we would not have otherwise been able to book.

I have read and understand this policy:

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

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.

Dear Patient,
Federal law requires Chiropractic Care Clinic to make this Notice of Privacy Practices ("Notice") available to all persons and to make a good faith effort to obtain a signed document acknowledging patients' receipt of this Notice.

Thank you,
Chiropractic Care Clinic

WHAT IS THE PURPOSE OF THIS NOTICE?

- The purpose of this Notice is to explain:
- How the clinic uses and releases your health information;
- Your rights concerning your health information; and
- The clinic's duties relating to your health information.

WHAT ARE THE CLINIC'S RESPONSIBILITIES TO YOU?

Your health information is personal. The Clinic is required by law to protect the privacy of your health information and to provide you with notice of the Clinic's legal duties and privacy practices that relate to your health information.

WHEN IS THE NOTICE EFFECTIVE?

The Notice is effective on the date shown at the top of this page. The Clinic reserves the right to change this Notice after the effective date and to make the revised Notice effective for all health information maintained by the Clinic (including existing health information as well as information the Clinic creates or receives in the future).

WHEN DO WE USE AND RELEASE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION?

The following paragraphs explain some of the situations in which the Clinic is permitted to use and release your health information without your express written authorization:

Treatment Purposes

The clinic may use and share your health information with other health care providers who are or will be involved in your treatment. Examples of these health care providers include: doctors, nurses, therapists, and laboratories.

Payment Purposes

The Clinic may use and share your health information in certain situations to obtain payment, or reimbursement, for the medical services, nutrition, or supplies provided to you.

Appointment Reminders

The Clinic may use your health information to remind you of scheduled appointments, recommended services, treatment alternatives, and other health-related benefits and services that may be of interest to you.

Worker's Compensation

The Clinic may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies

The Clinic may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of emergency.

As Required By Law

The Clinic may share your information with a federal, state, or local government agency or authority to the extent authorized or required by law. For example: The Clinic may be required by a court of law to share health information with the court pursuant to a court order.

Public Health Activities

The Clinic may share your health information with a federal, state, or local public health authority to carry out public health activities.

Abuse, Neglect, or Domestic Violence

The Clinic may share your health information with a federal, state, or local agency or authority to report a patient reasonably believed to be a victim of abuse, neglect, or domestic violence.

Health Oversight Agencies

The Clinic may share your health information with a federal, state, or local agency to assist such agencies with health oversight activities.

Judicial and Administrative Proceedings

The Clinic may share your health information to comply with an order of a court or administrative tribunal. For example, the Clinic may release your information to a court of law if the Clinic receives an order from the court requiring the release of information.

Law Enforcement Activities

The Clinic may share your health information with a federal, state, or local law enforcement officer or agency for certain law enforcement purposes. For example, the Clinic may share certain limited health information with a state police office in order to identify or locate a suspect, material witness, or missing person.

To Avoid a Serious Threat to Health or Safety

The Clinic may use and share your health information with a federal, state, or local government agency or authority to help avoid a serious threat to health or safety.

Specialized Government Functions

The Clinic may use and share your health information with a federal, state, or local government agency or authority for certain military and Veterans activities, certain national security and intelligence activities, and certain protective and correctional purposes.

Change of Ownership

In the event that Chiropractic Care Clinic is sold or merged with another organization, your health information/records will become the property of the new owner.

WHEN IS YOUR WRITTEN AUTHORIZATION REQUIRED BEFORE THE CLINIC MAY USE OR SHARE YOUR HEALTH INFORMATION?

Except for the situations listed above, the Clinic is required to obtain your prior written authorization before using or releasing your health information. If you authorize the Clinic to use or release your information, you may cancel, or revoke that authorization in writing at any time.

WHAT ARE YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION?

The clinic wants you to know that you have the following rights relating to your health information that is obtained or maintained by the Clinic:

Right to Receive this Notice of Privacy Practice

You have the right to receive a paper copy of this Notice at any time.

Right to Request Confidential Communications

You have the right to ask the Clinic to communicate your health information to you in different ways or places.

Right to Request Restrictions

You have the right to request restrictions or limitations on how the Clinic uses or releases your health information in certain situations. The Clinic may not agree to your request.

Right to Access

With a few exceptions, you have the right to review and receive a copy of your health information that is obtained or maintained by the Clinic. Some situations when you do not have the right to review or copy your health information include (1) when the information has been compiled in reasonable anticipation of a civil, criminal, or administrative action or proceeding; or (2) any information your provider feels you would commit serious harm to you or to others. The Clinic may charge you a fee to copy or mail your health information. If the Clinic denies you access to your health information, the Clinic will give you a written reason for the denial and information regarding how you can file an appeal if you are not satisfied with the Clinic's initial decision to deny you access to your health information.

Right to Amend

You have the right to ask the Clinic to amend your health information if your information is inaccurate or incomplete. The Clinic may deny your request if, among other reasons: (1) the Clinic did not create the health information at issue: (2) the Clinic does not maintain the health information at issue; (3) you are not allowed to access the information; or (4) the information is accurate and complete.

Right to a List of Information Releases

You have the right to request and receive a list or accounting of the situations when the Clinic has released your health information. The Clinic is not required to identify every information released in the list. If you request a record of releases more frequently than once per year, the Clinic any charge a fee for providing the list.

PRIVACY OFFICER CONTACT INFORMATION

If you have any questions about this Notice, wish to obtain any form to exercise a right described in this Notice, or wish to file a complaint, please contact the Clinic's Privacy Officer at:

Attn: Privacy Officer
Chiropractic Care Clinic
2924 Hawkins Drive
Searcy, AR 72143
501-268-2273

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE READ AND UNDERSTAND THE CONTENTS OF THIS NOTICE.

_____ _____

SIGNATURE DATE

Chiropractic Care Clinic
2924 Hawkins Drive
Searcy, AR 72143
501-268-2273

Chiropractic Care Clinic abides by all HIPAA (Health Insurance Portability & Accountability Act) Guidelines.

Patient Name _____ Relationship to Patient _____

Patient/Parent/Guardian Signature _____ Date _____

I give permission for Chiropractic Care Clinic (Doctor and/or Designated Representative) to release/discuss the following information:

[ ] Health Information [ ] Billing Information

With the following person(s):

Name _____ Relationship _____

Name _____ Relationship _____