

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____
Address: _____ Sex: Male / Female
City _____ State: _____ Zip: _____ Home Phone: _____
Social Security #: _____ Cell Phone: _____
Business Employer: _____ Business Phone: _____
Occupation: _____ Email Address: _____
Single/Married/Widow Name of Spouse: _____ Names & Ages of Children: _____
Referred To This Office By: _____
Name & Number of Emergency Contact: _____ Relationship: _____
Who is Responsible for your bill, you and Health Insurance Worker's Comp Auto Insurance Medicare Medical Assistance
Personal Health Insurance Carrier: _____ (Please provide card so a copy can be made.)
Insured Person's Name: _____ Insured Person's Date of Birth: _____
Insured Person's Social Security #: _____
Primary Care Physician: _____ Pharmacy: _____

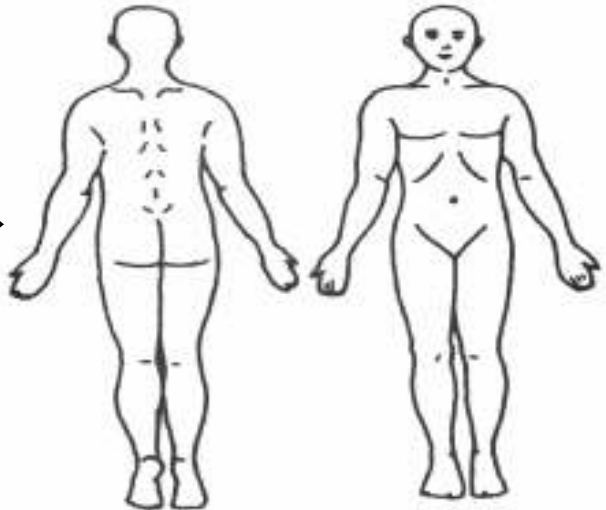
CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) _____

***PLEASE OUTLINE ON THE DIAGRAM
THE AREA OF DISCOMFORT***



When did this condition begin? _____
Has it ever occurred before? Yes No
Is condition: Auto Related Work Related Other No Injury
Explain: _____
Date of Accident: _____
Time of Accident: _____
Complaint/Pain Onset Date: _____
If Work: Have you filed an injury report with your employer? Yes No
Claim #: _____



Body Area Involved: Head/Neck Spine/Ribs/Pelvis Upper Extremity Lower Extremity

Condition Type: New Recurring Exacerbation Chronic

MECHANISM OF ONSET:

Work Overexertion Lifting Repetitive Motion Fall Other _____

Auto Slip/Fall Strain Recreation Gradual Increase in Discomfort

Level of Impairment Due to Symptoms (Resting): (0 = No pain, 10 = worst pain)

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

FREQUENCY:

Occasional (0-25%) Intermittent (26-50%) Frequent (51-75%) Constant (76-100%)

TYPE OF PAIN/QUALITY:

Sharp Stabbing Dull Aching Burning

Stiffness Numbness Tingling Soreness Other _____

Symptoms Worse With: Rest Activity Movement Bending Twisting Sitting

Standing Walking Nothing Apply Heat Apply Cold Other: _____

Symptoms Better With: Rest Activity Movement Bending Twisting Sitting

Exercise Walking Nothing Heat/Cold Massage Other: _____

TIMING:

Worse AM Worse PM Worse w/ Activity Constant Other _____

SELF MANAGEMENT ATTEMPTS:

Over The Counter Medication No Effect Temp Relief Imp/Not Resolved Worse

Medical Management No Effect Temp Relief Imp/Not Resolved Worse

Physical Therapy No Effect Temp Relief Imp/Not Resolved Worse

Massage No Effect Temp Relief Imp/Not Resolved Worse

Application of Ice/Heat No Effect Temp Relief Imp/Not Resolved Worse

Exercise No Effect Temp Relief Imp/Not Resolved Worse

Other doctors seen for this condition? Yes No Who? _____

Type of treatment: _____ Results: _____

Medications you now take: _____

Do you wear heel lifts? Yes No Inter Soles Yes No Arch Supports Yes No

Any other conditions you feel we should know about - even if unrelated? _____

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

- Childhood Illness:** ADD Allergies/Hayfever Asthma Atopic Dermatitis Cerebral Palsy Chicken Pox
 None Depression Diabetes Food Allergies Headaches Fetal Drug Exposure Hepatitis
 Measles Mumps Rash Seizure Disorder Sickle Cell Anemia Spina Bifida
 Unusual Childhood Illnesses

- Adult Illnesses:** Anemia Arthritis Asthma Cancer Chicken Pox Seizures
 None CVA (Stroke) Depression Eye Problems Heart Disease Hepatitis Hypertension
 Kidney Disease Liver Disease Lung Disease Thyroid STD's Psychiatric Problems
 CRPS (RSD) Diabetes (NIDDM - Noninsulin) Diabetes (Insulin Dep) Suicide Attempts
 Similar Symptoms

- Surgeries:** Appendectomy Gallbladder Hernia Repair Spinal Fusion Laminectomy Joint Reconstruction
 None Joint Replaced Carpal Tunnel Hysterectomy D&C Mastectomy Caesarean Section
 Cardiac Cath. Angioplasty Pacemaker Coronary Bypass Cosmetic Hemorrhoidectomy
 Other _____

Ob/Gyn: Describe: _____
 None

Significant Injuries: Describe: _____
 None

- Immunizations:** Flu Hepatitis A Hepatitis B Hepatitis C MMR Pneumonia PPD
 None TB Varivax Small Pox

Non-Drug Allergies: Describe: _____
 None

FAMILY HISTORY

	Alive	Deceased	Condition
General Family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Son(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Daughter(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

OCCUPATION

Job Title: _____ **Work Hours Per Day:** _____

Max Lifting Req't: Sed.(<5 lbs) Light (5-20 lbs) Med (20-50lbs) Heavy (>50 lbs)

Lifting Frequency: Constant (66-100%of day) Frequent (33-66% of day) Occasional (0-33% of day)

Lifting Postures: Knee Torso Arm Shoulder

Work Activity Postures:

Sitting: _____ Hrs per day Standing: _____ Hours per day Walking: _____ Hrs per day
Climbing: _____ Hrs per day Pushing: _____ Hours per day Pulling: _____ Hrs per day
Kneeling: _____ Hrs per day Reaching: _____ Hours per day Twisting: _____ Hrs per day

Repetitive Activities:

Computer: _____ Hrs per day Phone: _____ Hours per day Machinery: _____ Hrs per day
Hand Tools: _____ Hrs per day Assembly: _____ Hours per day Grasping: _____ Hrs per day
Other: _____ / _____ Hrs per day

Impact of Current Condition on Work Capacity: No Effect Painful Limits Unable

RECREATIONAL ACTIVITY

Effect of Current Condition on Performance

No Effect Painful Limits Unable
No Effect Painful Limits Unable
No Effect Painful Limits Unable
No Effect Painful Limits Unable
No Effect Painful Limits Unable

DAILY ACTIVITIES

Washing/Bathing

No Effect Painful Limits Unable

Household Chores

Sweeping/Vacuuming

No Effect Painful Limits Unable

Dishes

No Effect Painful Limits Unable

Laundry

No Effect Painful Limits Unable

Yardwork

No Effect Painful Limits Unable

Garbage

No Effect Painful Limits Unable

Other: _____

No Effect Painful Limits Unable

Climbing Steps

No Effect Painful Limits Unable

Lifting Groceries

No Effect Painful Limits Unable

Dressing

No Effect Painful Limits Unable

Sleep

No Effect Painful Limits Unable

Driving

No Effect Painful Limits Unable

Concentration (Reading)

No Effect Painful Limits Unable

Sexual Activity

No Effect Painful Limits Unable

Alcohol Use: None Beer Liquor Social Consumption Wine Amount _____

Diet: High Fat Diet High Fiber High Protein High Salt Intake Low Calorie Intake Low Carbohydrate
 Low Fiber Low Salt Low Sugar No Restrictions

Substance: Denies Any Denies IV Drugs Not Used Since _____ Used Drugs For _____

Tobacco: Type _____ Amount _____

Education: Level or Degree Attained: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if “NONE”.

Constitutional: Chills Daytime Drowsiness Fatigue Fever Night Sweats Weight Gain
 None Weight Loss

Eyes/Vision: Blindness Blurred Vision Cataracts Change in Vision Double Vision Eye Pain
 None Field Cuts Glasses/Contacts Glaucoma Itching Photophobia Tearing

ENT: Bleeding Dentures Difficulty Swallowing Discharge Dizziness Ear Drainage
 None Ear Pain Fainting Frequent Sore Throats Headaches Hearing Loss History of Head Injury
 Hoarseness Loss of Smell Nasal Congestion TMJ Nose Bleeds
 PND (Post Nasal Drip) Rhinorrhea (Runny Nose) Sinus Infections Snoring Tinnitus (Ringing in Ears)

Respiration: Asthma Cough Coughing up Blood Shortness of Breath (SOB) Sputum Production
 None Wheezing Emphysema

Cardio: Angina Chest Pain Claudication Heart Murmur Heart Problems Orthopnea Palpitations
 None SOB with Exertion Swelling of Legs Ulcers Varicose Veins High Blood Pressure

Gastro: Abdominal Pain Belching Heartburn Indigestion Nausea Difficulty Swallowing Vomiting
 None Vomiting Blood Regurgitation Jaundice Constipation Diarrhea
 Hemorrhoids Rectal Bleeding Black Tarry Stools Stool Caliber
 Stool Color Stool Consistency

Female: Breast Lumps/Pain Burning Urination Cramps Frequent Urination Irregular Menstruation
 None Urine Retention Vaginal Bleeding Vaginal Discharge Blood in Urine

Male: Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate
 None Urine Retention Blood in Urine

Endocrine: Cold Intolerance Heat Intolerance Diabetes Excessive Appetite Excessive Hunger
 None Excessive Thirst Frequent Urination Goiter Hair Loss Unusual Hair Growth Voice Changes

Skin: Hair Growth Hair Loss Hives Itching Rash Pruritis Paresthasias History of Skin Disorders
 None Changes in Skin Color Skin Lesions/Ulcers Varicosities Changes in Nail Texture Cancer

Nervous: Dizziness Facial Weakness Headache Limb Weakness Loss of Consciousness Loss of Memory
 None Numbness Unsteadiness of Gait Slurred Speech Stress Strokes Paralysis Tremor Seizures

Psychologic: Anhedonia Anxiety Appetite Behavioral Change Bipolar Confusion
 None Depression Insomnia Memory Loss Mood Change

Allergy: None Anaphylaxis Itching Sneezing Nasal Congestion Food Intolerance

Hematology: Anemia Bleeding Blood Clotting Blood Transfusions Bruising Fatigue
 None Lymph Node Swelling Coumdin Aspirin Hemophilia Sickle Cell

Musculoskeletal: Muscle Pain Joint Pain Joint Stiffness Osteoarthritis Gout Rheumatoid
 None

Signature _____

Date: _____

Worker's Compensation Questionnaire

Name of Compensation Carrier _____ Phone () _____

Address of Carrier _____ City _____ State ____ Zip _____

Employer's Name _____ Phone () _____

Employer's Address _____ City _____ State ____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date Injured _____ Hour ____ AM/PM Last Date Worked _____ Are you off work? Yes No

3. Previous Workers' Compensation Injury: Yes No

4. Accident reported to employer? () Yes () No Name of person reported accident to _____

5. Injured at _____ City _____ State ____ Zip _____

6. Length of time worked there prior to accident _____

7. Type of work being done at time of injury _____

8. In your own words, please describe accident _____

9. Have you been treated by another doctor for this accident? Yes No

If yes, please list doctor's names and addresses _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

10. Are you: improved unchanged getting worse

11. What types of medications are you taking? _____

12. Have you had physical therapy help? Yes No If yes, how often?: Daily Every other day

Several times a week Weekly Every other week Monthly Other _____

Does the physical therapy help? Yes No Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

Yes No Don't know

If yes, describe: _____

Were these similar complaints the result of a previous accident(s)? Yes No

Please provide details of the accident(s) _____

14. Have you had any other serious accidents which required medical care? Yes No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? Yes No

Describe: _____

16. Have you had any surgeries? Yes No

If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses? Yes No

Have you had psychiatric care? Yes No

18. Have you received a medical discharge from the Armed Forces? () Yes () No

19. Have you returned to work since this accident? Yes No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	Light Duty Regular Duty	Part Time Full Time

CURRENT MEDICAL COMPLAINTS

Back Pain

1. Currently, I have pain in my: low back mid back upper back

2. My pain began: gradually suddenly

3. I have pain: sometimes all of the time

4. My pain goes into my: right leg left leg both

5. I have tingling and/or numbness in my: right leg left leg both

6. My pain is worse when I:

Cough & Sneeze	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sit	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bend	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walk	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lift	<input type="checkbox"/> Yes <input type="checkbox"/> No	Push	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pull	<input type="checkbox"/> Yes <input type="checkbox"/> No		

7. My back is worse with sexual activity Yes No

8. My pain wakes me up during the night Yes No

9. Changes in the weather affect my pain Yes No

Neck Pain:

- 1. My neck pain began: gradually suddenly
- 2. I have pain: sometimes all of the time
- 3. My pain goes into my: right arm left arm both
- 4. I have tingling and/or numbness in my right arm left arm both
- 5 My pain is worse when I:

Cough & Sneeze	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lift	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bend Forward	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pull	<input type="checkbox"/> Yes <input type="checkbox"/> No
Turn my Head	<input type="checkbox"/> Yes <input type="checkbox"/> No	Push	<input type="checkbox"/> Yes <input type="checkbox"/> No
- 6. My pain wakes me up during the night Yes No
- 7. Changes in the weather affect my pain Yes No
- 8. I have neck stiffness Yes No
- 9. I have headaches Yes No
- 10. If I do get headaches, they occur sometimes all of the time

OTHER PAIN

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding you condition: _____

JOB DESCRIPTION

(In terms of an 8-hour workday, "occasional" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8 hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend / stoop	()	()	()	()
Squat	()	()	()	()
Crawl	()	()	()	()
Climb	()	()	()	()

	Not at all	Occasionally	Frequently	Continuously
Reach above shoulder level	()	()	()	()

Crouch	()	()	()	()
Kneel	()	()	()	()
Balancing	()	()	()	()
Pushing / Pulling	()	()	()	()

3. On the job, I lift:	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	()	()	()	()
11 to 24 pounds	()	()	()	()
25 to 34 pounds	()	()	()	()
35 to 50 pounds	()	()	()	()
51 to 74 pounds	()	()	()	()
75 to 100 pounds	()	()	()	()

4. Do you have to bend over while doing lifting? Yes No

5. Are your feet used for repetitive movements, such as in operating foot controls? Yes No

6. Do you use your hands for repetitive actions, such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Are you required to work on unprotected heights? Yes No

Describe: _____

8. Are you required to be around moving machinery? Yes No

Describe: _____

9. Are you exposed to marked changes in temperature and humidity? Yes No

Describe: _____

10. Are you required to drive automotive equipment? Yes No

Describe: _____

11. Are you exposed to dust, fumes and/or gases? Yes No

Describe: _____

12. Please list any additional comments: _____

Signature: _____ Date: ___/___/___

Privacy Notice (NOPP)

This notice describes how medical information about you may be used and disclosed and how you can get access to that information

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

The Practice may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Practice to use and/or disclose your PHI for the purposes of:

Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice’s staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.

Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice’s personnel in providing care to you.

Appointment Reminders - The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: **a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.**

Sign-In Log - The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice’s offices.

Open Treatment Areas – There are areas within the practice where conversations with you regarding your care may be overheard. If at any time you are uncomfortable regarding these conversations, please let a staff member know and every attempt will be made to locate a private location for your conversation.

Treatment Alternatives - We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services - We may tell you about health-related products or services that may be of interest to you.

SPECIAL SITUATIONS

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following instances:

A. De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

B. Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

C. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

D. Emergency Situations – for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

E. Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

F. Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

G. Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

H. Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

I. Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

J. Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

K. Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

L. Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

M. Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

N. Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

O. Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.

P. Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Q. National Security and Intelligence Activities – The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

R. Military and Veterans – If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

A. If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

B. If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above will be made only with your written Authorization. We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing. You will not be penalized for filing a complaint.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Dr. Richard J. Prough Jr.

PRACTICE'S REQUIREMENTS

The Practice:

- A. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- B. Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law.
- C. Is required to abide by the terms of this Privacy Notice.
- D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

This notice is in effect as of 03/01/2007

Privacy Form

PATIENT ACKNOWLEDGMENT

**For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment, and Healthcare Operations**

_____,
(Name)

hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The **Practice’s Privacy Notice** has been provided to me prior to my signing this Consent. The **Privacy Notice** includes a complete description of the uses and/or disclosure of my **Protected Health Information** (“PHI”) necessary for the **Practice** to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it’s health care operations. The **Practice** has further explained my right to obtain a copy of the **Privacy Notice** prior to my signing this Consent and has encouraged me to read the **Privacy Notice** carefully prior to my signing this Consent.
2. The **Practice** reserves the right to change its **Privacy Practices** that are described in its **Privacy Notice**, in accordance with applicable law.
3. The **Practice’s “Notice of Privacy Practices”** is also provided upon request at this office and is available on the **Practice’s** website at *www.proughchiro.com*. I may also request a copy from this office at any time via U.S. Mail.
4. This **Notice of Privacy Practices** also describes my rights and the duties of this office with respect to my Protected Health Information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Print Name of Individual

Signature of Individual Date Signed _____

Signature of Legal Representative Date Signed _____

Relationship

Witness

*The “Practice” in this document
refers to the Prough Chiropractic.*