Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance card(s).
All information you supply is confidential. We comply with all federal privacy standards.

Name_____ Home Phone_____

Address_____ Work Phone_____

City, State, Zip_____ Cell Phone_____

Birth date_____ Age_____ E-mail Address_____

SS# xxx-xx-_____ Primary Doctor (Full Name & Facility) _____

Occupation_____ Employer_____

Marital Status: M W Sep. D Sin Spouse Name_____ No. of Children_____

Contact in case of emergency_____ Phone #_____

Preferred method of contact: □ Text Message □ Email □ Cell Phone □ Home Phone

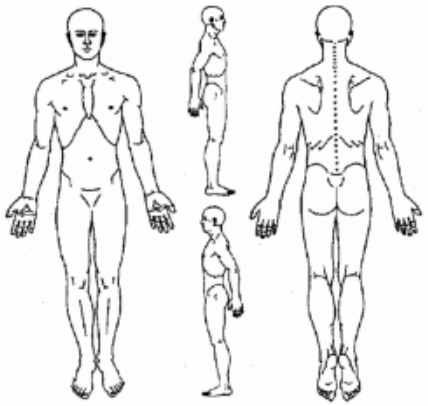
How did you hear about our office? _____

Spinal health is especially important when you are pregnant. Is there any chance that you are pregnant? **Y N**

Auto & work injuries can cause serious spinal problems. Is this visit related to an auto accident or work injury? **Y N**
Date and description of injury: _____

PLEASE COMPLETE ALL OF THE FOLLOWING SECTIONS TO THE BEST OF YOUR ABILITY!

(Please mark on the diagram exactly where you are experiencing pain)



What is your MAJOR COMPLAINT: _____

Does the pain travel to any of the following areas?

□ Left Shoulder	□ Right Shoulder	□Left Buttock	□Right Buttock
□ Left Arm	□ Right Arm	□Left Leg	□Right Leg
□ Left Hand	□ Right Hand	□Left Foot	□Right Foot

What do you think caused your symptoms? _____
_____

When did the symptoms start? _____

Rate Your Current Pain: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe
Rate Your Pain at its Worst: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe

How often are you experiencing symptoms?
□ Occasional (25% or less) □ Intermittent (26-50%) □ Frequent (51-75%) □ Constant (76-100%)

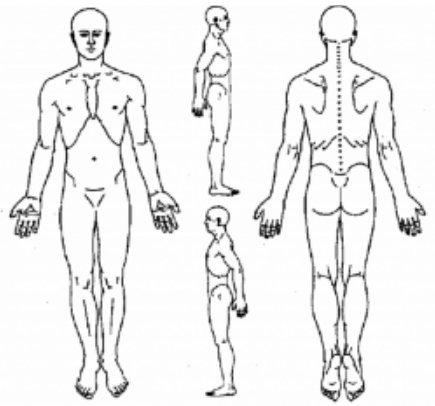
How would you describe the symptoms you are currently feeling? (Check all that apply):
□ Achy □ Burning □ Catching □ Cramps □ Dull □ Nagging □ Numbness □ Pinching □ Sharp
□ Shooting □ Sore □ Stabbing □ Stiffness □ Tight □ Tingling □ Tired/Weak □ Throbbing

What makes your symptoms WORSE? (Check all that apply):
□ Nothing □ Bending □ Cough/Sneeze □ Inactivity □ Lifting □ Lying down □ Movement/exercise
□ Reaching □ Sitting □ Standing □ Twist/ Turn □ Walking □ Morning □ Midday □ Evening
□ Other: _____

What makes your symptoms BETTER? (Check all that apply):
□ Nothing □ Heat □ Ice □ Inactivity/Rest □ Lying Down □ Movement/exercise □ Pain medication □ Sitting
□ Standing □ Stretching □ Walking □ Morning □ Midday □ Evening □ Other:_____

What is your SECONDARY COMPLAINT: _____

(Please mark on the diagram exactly where you are experiencing pain)



Does the pain travel to any of the following areas?

□ Left Shoulder □ Right Shoulder □Left Buttock □Right Buttock
□ Left Arm □ Right Arm □Left Leg □Right Leg
□ Left Hand □ Right Hand □Left Foot □Right Foot

What do you think caused your symptoms? _____
_____

When did the symptoms start? _____

Rate Your Current Pain: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe
Rate Your Pain at its Worst: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe

How often are you experiencing symptoms?

□ Occasional (25% or less) □ Intermittent (26-50%) □ Frequent (51-75%) □ Constant (76-100%)

How would you describe the symptoms you are currently feeling? (Check all that apply):

□ Achy □ Burning □ Catching □ Cramps □ Dull □ Nagging □ Numbness □ Pinching □ Sharp
□ Shooting □ Sore □ Stabbing □ Stiffness □ Tight □ Tingling □ Tired/Weak □ Throbbing

What makes your symptoms WORSE? (Check all that apply):

□ Nothing □ Bending □ Cough/Sneeze □ Inactivity □ Lifting □ Lying down □ Movement/exercise
□ Reaching □ Sitting □ Standing □ Twist/ Turn □ Walking □ Morning □ Midday □ Evening
□ Other: _____

What makes your symptoms BETTER? (Check all that apply):

□ Nothing □ Heat □ Ice □ Inactivity/Rest □ Lying Down □ Movement/exercise □ Pain medication □ Sitting
□ Standing □ Stretching □ Walking □ Morning □ Midday □ Evening □ Other:_____

PLEASE COMPLETE ALL OF THE FOLLOWING SECTIONS TO THE BEST OF YOUR ABILITY

Activities of Daily Living -- How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	□	□	□	□	Grocery shopping	□	□	□	□
Rising out of chair	□	□	□	□	Household chores	□	□	□	□
Standing	□	□	□	□	Lifting objects	□	□	□	□
Walking	□	□	□	□	Reaching overhead	□	□	□	□
Lying down	□	□	□	□	Showering or bathing	□	□	□	□
Bending over	□	□	□	□	Dressing myself	□	□	□	□
Climbing stairs	□	□	□	□	Physical Relationship	□	□	□	□
Using a computer	□	□	□	□	Getting to sleep	□	□	□	□
Getting in/out of car	□	□	□	□	Staying asleep	□	□	□	□
Driving a car	□	□	□	□	Concentrating	□	□	□	□
Looking over shoulder	□	□	□	□	Exercising	□	□	□	□
Caring for family	□	□	□	□	Yard work/Gardening	□	□	□	□
Occupation	□	□	□	□	Using the restroom	□	□	□	□
Hobbies	□	□	□	□	Twisting/Turning	□	□	□	□

Have you had Spinal Surgery: Y N **When (approx.)**:_____

Do you have any permanent hardware as a result of surgery? Y N

Please list all surgeries you have had: _____
_____

List the 4 most traumatic injuries you have had throughout your lifetime:

1. _____
2. _____
3. _____
4. _____

Current Medications/Nutritional Supplements: List ANY/ALL medications/nutritional supplements you are CURRENTLY taking. Be Specific.

Medication/Nutritional Supplement	Dosage	For What Condition?	How long have you been taking this?

Review of Symptoms-- YOU MUST COMPLETE ALL OF THE FOLLOWING SECTIONS!!
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.

Please indicate with a (C) **Conditions you have now** or with a (P) the **conditions you have had in the past.**

a. Musculoskeletal

___ Osteoporosis ___Arthritis ___Scoliosis ___Neck pain ___Back Pain ___Hip disorders
___ Knee injuries ___Foot/ankle pain ___ Shoulder pain ___Elbow/wrist pain ___TMJ issues ___Poor posture
___Broken/Fractured bones ___Fibromyalgia ___Spinal Degeneration ___Spinal Disc Problems

b. Nervous System

___Facial weakness ___Limb weakness ___Loss of consciousness ___Seizures ___Slurred speech ___Stress ___Tremors
___Unsteadiness of gait/loss of balance ___Headaches ___Dizziness ___Pins/Needles ___Numbness ___ Epilepsy ___ Concussion
___Trouble concentrating ___Tingling ____Multiple Sclerosis ___ Alzheimer's Disease ____Dementia ___Parkinson's Disease

c. Cardiovascular

___High blood pressure ___Low Blood pressure ___High cholesterol ___Poor circulation ___Angina ___Excessive bruising
___Chest pain ___Claudication (leg pain/ache) ___Heart murmur ___Heart problems ___Orthopnea (difficulty breathing lying down)
___Palpitations ___Paroxysmal nocturnal dyspnea (waking at night with shortness of breath) ___Swelling of legs ___Varicose veins
___Stroke ___Arteriosclerosis ___Rheumatic fever

d. Respiratory

___Asthma ___Apnea ___Emphysema ___Cough ___Wheezing ___Hay fever ___Shortness of breath ___Pneumonia
___Tuberculosis ___Sleep Apnea

e. Gastrointestinal/Digestion

___Anorexia or bulimia ___Ulcer ___Food sensitivity ___Heartburn ___Constipation ___Diarrhea ___Abdominal pain
___Belching ___Black-tarry stool ___Difficulty swallowing ___Hemorrhoids ___Indigestion ___Jaundice ___Nausea
___Rectal bleeding ___Abnormal stool color/consistency ____ Blood in stool ___Vomiting ___Vomiting blood
___Gallbladder trouble ___Diverticulitis ___Colitis ___Irritable Bowel Syndrome

f. Sensory

___Blurred vision ___Ringing in ears ___Hearing loss ___Chronic ear infection ___Loss of smell ___Loss of taste

g. Integumentary

___Skin cancer ___Psoriasis ___Eczema ___ Acne ___Hair loss ___Rash ___Changes in nail texture
___Changes in skin color ___Hair growth ___Hives ___History of skin disorder ___Itching ___Paresthesia ___Skin lesions
___Varicosities

h. Endocrine

___Thyroid issues ___Immune disorders ___ Hypoglycemia ___Frequent infections ___Swollen glands ___Low energy
___Cold intolerance ___Diabetes ___Excessive appetite ___Excessive hunger ___Excessive thirst ___Abnormal frequency of urination
___Goiter ___Hair loss ___Heat intolerance ___Unusual hair growth ___Voice changes ___Hands/feet cold ___Sweaty palms
___Chronic Fatigue Syndrome

i. Genitourinary

___Kidney stones ___Infertility ___Bedwetting ___Prostate issues ___ Erectile Dysfunction ___PMS symptoms ____Menopause

j. Constitutional

___Fainting ___ Low libido ___Poor appetite ___Fatigue ___Sudden weight gain/loss (circle one) ___Weakness

k. **Psychologic**

___Insomnia ___Anxiety ___ Behavioral changes ___ Bi-polar disorder ___Confusion ___Convulsions ___Depression
___Memory loss/Recall problems ___Mood changes ___Loss or change in appetite _____ PTSD ___ Brain Fog

l. Allergy

___Anaphylaxis ___Food intolerance ___Itching ___Acute nasal congestion ___Chronic nasal congestion ___Sneezing

m. Hematologic

___Anemia ___Bleeding ___Blood clotting ___Blood transfusion ___Bruising easily ___Lymph node swelling

n. Illnesses/Other- Do you have or suffer from any of the following?

___Pacemaker ___Learning disability ___Cancer ___Frequent flu/colds ___Alcoholism ___Drug addiction ___AIDS
___Chicken pox ___Glaucoma ___Gout ___Hepatitis ___HIV positive ___Malaria ___Mumps ___Polio ___Scarlet fever
___Sexually transmitted disease ___ Lyme Disease ___Focus and Attention Challenges ___Sleep issues ____Attention deficit disorder

How will you be paying for your visit? Cash___ Check___ Visa___ MasterCard___ Discover___

We are Out of Network providers for all Healthcare Insurance Companies, with the exception of Novitas Medicare- Part B. What an Out of Network provider means is that we do not have an agreement or contract with that insurance company. Because our doctors are Out of Network providers, we require all our patients to pay at the time of service. As a courtesy to all our patients, we will verify your insurance coverage and send your visits/claims to your specific insurance company. If there is any reimbursement for your care, your insurance company will send any such payment and/or correspondence directly to you/policy holder.

For patients who have Novitas Medicare - Part B coverage, adjustments may be considered for insurance coverage depending upon patient's deductible, diagnosis and frequency. If additional therapies are needed, Novitas Medicare- Part B will not consider them for coverage, only the chiropractic adjustment.

Patient or Guardian Initials: _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is evaluation of my physical health and the potential for improvement. I understand that all fees are due and payable at the time of service.

Patient or Guardian Signature: _____ Date: ____/____/____

FINANCIAL AND HEALTHCARE INSURANCE POLICIES

Please read the information below regarding our office payment policies and healthcare insurance. If you have any questions, prior to signing, please let us know**. Your signature and initials below certify that you understand your financial responsibility for services and/or care received**.

PAYMENTS METHODS ACCEPTED

Accepted payment methods include Cash, Check, Visa, MasterCard, Discover & American Express.
Returned checks will result in a $25.00 service fee.

AFTER HOURS/EMERGENCY APPOINTMENTS

Emergency and/or after hours or weekend appointments **may** result in an additional $75.00 fee. Initial: _____

NOVITAS MEDICARE PART B COVERAGE TERMS

We are In Network providers for Novitas Medicare. Chiropractic care falls under the Part B Benefit.
Novitas Medicare-Part B, will only consider the Chiropractic Adjustment for coverage. If x-rays or therapies, other than the Chiropractic Adjustment are recommended, please understand that you will be responsible to pay for those services at the time of service because Novitas Medicare-Part B DOES NOT cover them. Having Novitas Medicare-Part B does not guarantee coverage. Novitas Medicare-Part B has specific guidelines and criteria that must be met, in order to have insurance coverage considered. **This section is for Patients who HAVE Novitas Medicare Part B Insurance Benefits: Please Read, Initial and Date or Write N/A by Initials if it DOES NOT apply to you.**

Initial: _____

FINANCIAL/INSURANCE TERMS & POLICY

We are Out of Network providers for all Healthcare Insurance Companies, with the exception of Novitas Medicare- Part B. As a courtesy to all our patients, we will verify your insurance coverage and submit your claims to your specific insurance company.
Because we are Out of Network providers, we require all our patients to pay at the time of service. (The only exception for non-payment at the time of service is for Novitas Medicare-Part B patients, as stated above.) If there is any insurance reimbursement, your insurance company is to send/mail that directly to you. If you have any questions, when you receive your Explanation of Benefits from your insurance company, please feel free to bring a copy in and our insurance personnel will be happy to help clarify any questions. Please note that our office does not receive a copy of the Explanation of Benefits from your insurance company.

Initial: _____

APPOINTMENT CANCELLATIONS

We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient in need of care. When your appointment is made, a room is reserved, your records are prepared and reviewed and specific accommodations are made for your individualized treatment plan. Except in the case of an emergency treatment for another patient, you can expect our team to be ready to begin your treatment at your scheduled appointment time. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, call us as soon as you can so we may accommodate another patient at that time.

Initial: _____

NO-SHOWS

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed unnecessarily. We track all missed (no-show) appointments. A "No Show/Late Cancellation" is defined as a patient missing an appointment without cancelling or providing notification to our office within at least 24 hours prior to their scheduled appointment time. There will be a **charge of $45.00 for each missed or non-cancelled appointment**. A form of payment will be required to put on file and fees will automatically be charged in the event of a "No-Show/Missed/Late Cancellation" appointment. Repeated missed appointments may result in your chiropractor discharging you from the practice.

Initial: _____

INFORMED CONSENT-TERMS OF ACCEPTANCE

Assignment and Release of Benefits

By signing below, I certify that to the best of my knowledge the information I have provided is accurate, truthful and current. I understand that **1)** I am financially responsible for all charges whether or not paid by insurance and **2)** I am financially responsible for any legal fees or other fees incurred by NBCTMH DC, PLLC d/b/a/ Horn Family Chiropractic for collection efforts of delinquent balances on my and/or my dependent(s) account(s). I authorize the use of my signature on all insurance submissions. NBCTMH DC, PLLC d/b/a Horn Family Chiropractic may use my health care information and may disclose such information to the provided insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits. The consent will end when my current treatment plan is completed or one year from the date below. I consent to treatment for myself and/or treatment for my minor dependent(s) and guarantee payment for all services rendered by NBCTMH DC,PLLC d/b/a Horn Family Chiropractic whether insurance pays or not.

Terms of Acceptance and Informed Consent

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stoke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for you condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Consent to Treatment, Guarantee of Payment and Release of Information

I hereby consent to examination and all treatments of myself or my minor dependents(s) for whom I am responsible. I guarantee payment for all services rendered regardless of my results or whether my insurance company(s) contributes or does not contribute toward payment for my care or care of minor dependent(s). **I authorize NBCTMH DC, PLLC d/b/a Horn Family Chiropractic to release my health and personal information for the purpose of billing, insurance submission, doctor referrals, insurance requests, employer test results, governmental agencies, etc. as required by law and allowed by law.**

Print Patient Name: _____ **Date:** _____

Patient or Parent/Guardian Signature: _____ **Date:** _____

OFFICE PRIVACY POLICY
Comprehensive Notice of Privacy Practices
NBCTMH DC, PLLC d/b/a Horn Family Chiropractic

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required 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.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, 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 may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic 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.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition We may call you by name in the waiting, therapy and/or adjusting room. We may use your personal contact information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine, voice mail or by text. Most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency. In addition video surveillance is in use on the premises. We may disclose your health information to your primary care physician unless you specifically request in advance for us not to.

We may share your protected health information with third party "business associates" that perform various activities (e.g., electronic billing or 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 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 marketing activities. For example, your name and 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 Contact to request that these materials not be sent to you.

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. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic 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 Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. 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 chiropractor 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 specifically identify, your protected health information that directly relates to that person's involvement in your chiropractic 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 a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. 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 relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

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.

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, health operations or additional uses listed above in paragraph 8. 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 chiropractor is not required to agree to a restriction that you request. If your chiropractor 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 chiropractor 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.

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 this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor 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.

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.

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 electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Jody Horn, Office Manager (570) 882-9009 Fax (570) 882-9011
29767 Route 220, Athens, PA 18810

I consent to the use and disclosure of protected health information by Nathaniel B. Callear D.C., Trey M. Hildebrandt D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

Would you like a copy of this Privacy Policy? Circle one: YES NO

Printed Patient Name _____ Date _____

Patient or Parent/Guardian Signature _____

Printed Name of Parent/Guardian _____