Comprehensive Health Profile

Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ SSN: _____ Occupation: _____

Marital Status: S M D W Partner's Name: _____ Do you have children? **Y N**

Who referred you or how did you hear about our office? _____

Do you have insurance you want us to bill for your care? _____

What are your reasons for seeking care at our office? Please rank the following
(4=Very Important to me; 3=Important to me; 2=Not so Important to me; 1=Does not apply)

___Improvement of my physical symptoms
___Improvement of my emotional/mental symptoms
___Improvement in my ability to respond to stress
___Improvement in my enjoyment/quality of life

Your Symptoms and How They May Influence Your Life:

Do you have a current health/life concern or symptom? If no, please describe the reason you are consulting our office then skip to History of Physical Stress Section. If yes, please describe: _____

_____

When did it begin? _____ What were the circumstances? _____

Is the reason you are consulting our office the result of an injury at work or an auto accident? **Y N** If so, date of injury? _____

Have you done anything about this concern, or been given any advice or treatment for it? **Y N** If yes, what were you told and by whom? _____

_____

What was done? _____

Did it seem to work? **Y N** What was different about your symptom or concern after treatment? _____

_____

Please grade the level to which the concern/symptom affects the following aspects of your functioning/quality of life (0=does not seem to affect me; 1=slightly affects me; 2=moderately; 3=extremely)

Work	0 1 2 3	Recreation/Play	0 1 2 3	Rest/Sleep	0 1 2 3
Social Life	0 1 2 3	Walking	0 1 2 3	Sitting	0 1 2 3
Exercise	0 1 2 3	Eating	0 1 2 3	Love Life	0 1 2 3

Comments: _____

Have any other family members had the same or similar concerns? **Y N**

What did he/she do about it? _____

Did it seem to work? **Y N** How aware are you of your symptom/concern during the day? 0 1 2 3 at night? 0 1 2 3

Is there any activity during which you totally, or almost totally, forget about this condition, symptom, or concern? ___

_____

_____

Why do you think this is happening, or continues to happen to you? _____

_____

Do you think this is the sole cause? **Y N** If no, what else is involved? _____

_____

Are you doing anything differently in your life because of this symptom/condition/concern? **Y N** If yes, what? _____

_____

If it were to go away tomorrow, what would be different about your life? _____

_____

Since the development of this symptom/concern, have you:

Changed any habits? **Y N** If so, what? _____

Held or touched a part of your body more often or differently? **Y N**

Moaned, cried, or made sounds that you usually do not make? **Y N**

Which best describes your current feeling about yourself and your situation?

___I feel helpless, like little or nothing is working.
___I feel stuck.
___This is terrible, really bad; I hope you can fix it for me.
___I deserve more than this, and would like you to assist me with my healing.
___Other, please describe: _____

HISTORY OF PHYSICAL STRESS

Birth Stress: Were there any problems associated with your mother's pregnancy with you? (check all that apply)
☐Falls/Injury ☐Illness ☐Difficult ☐Don't know
Comments: _____
Was your birth: (check all that apply) ☐Traumatic ☐"C" section ☐Breech ☐Forceps or Suction ☐Cord around neck ☐Prolonged ☐Very Fast ☐Natural ☐Drug induced ☐Home ☐Hospital ☐Birthing Center
Comments: _____

General Physical Trauma: Falls: (check all that apply, give age & year) ☐Crib/Carriage _____ ☐Steps _____ ☐On ice _____ ☐Out of Tree _____ ☐Bars at school _____ ☐Skiing/Snowboarding _____ ☐Other falls (please describe): _____
☐Knocked unconscious _____ ☐Used crutches/cane _____ ☐Broken Bones/Sprains (please describe)_____
_____
☐Involved in combat _____ ☐Physical fight _____ ☐Physical abuse _____ ☐Sports Injuries_____
☐Extensive dental work/orthodontia _____ ☐Other, please describe: _____
_____

Accidents, near accidents, driver or passenger: (check all that apply, give age & year)
☐Automobile, details: _____
☐Motorcycle _____ ☐Bus _____ ☐Train _____ ☐Bicycle _____ ☐Plane _____ ☐Other: _____Comments: _____

Daily Activities: (check all that apply)
☐Sit ☐Stand ☐Walk ☐Desk work ☐Phone work ☐Sports ☐Exercise ☐Computer work
☐Watch TV ☐Driving/commuting ☐Play musical instrument ☐Read for prolonged periods
☐Mechanical work ☐Heavy lifting ☐Wear contacts ☐Wear glasses ☐Wear bifocals
☐Comments: _____
_____

Medical Intervention: (check all that apply, give age & year)
☐Hospitalization *why?* _____
☐Surgery *why?* _____
☐Chemotherapy _____ ☐Radiation _____ ☐Casts/Collars _____
☐Spinal/neck brace _____ ☐Corrective shoes. bars, lifts _____ ☐Physical Therapy _____ ☐Spinal tap/injections _____ ☐X-rays _____
☐Transfusion _____ ☐Organ Removal _____ Comments: _____
_____
Have you or a family member suffered a serious illness? _____
Do you have a family doctor? **Y N** Who? _____
Date of last medical consultation & result: _____
For women: Are you pregnant? **Y N** Date of last monthly period: _____
How do you grade your overall physical health? ☐Excellent ☐Good ☐Fair ☐Poor ☐Getting Better ☐Getting Worse

HISTORY OF CHEMICAL STRESS

Birth Stress: During your mother's pregnancy, did she: (check all that apply)
☐Use prescription drugs ☐Use nonprescription drugs ☐Smoke ☐Consume alcohol/drugs ☐Don't know
At birth was your mother: (check all that apply) ☐Conscious ☐Semi-conscious ☐Unconscious ☐Given spinal anesthesia ☐Given chemicals to alter or induce labor ☐Don't know

General Chemical Stress: Do you or have you ever taken: (check all that apply) ☐Prescription drugs ☐Over-the–counter drugs ☐Antibiotics ☐Other drugs ☐Tobacco
List all current and past Medications: (include reason and length of time you were on them) _____
_____
_____
_____

Do you or have you worked with or ever been exposed to: ☐Chemicals ☐Fumes ☐Dust ☐Powders/Particles ☐Smoke ☐ Other substances_____

Do you consume: ☐Alcohol ☐Coffee/caffeine ☐Processed food ☐Artificial sweeteners ☐Refined sugar ☐Sodas ☐Tap water Describe diet: _____

HISTORY OF EMOTIONAL STRESS

Were you incubated or isolated after birth? **Y N** Were you: ☐Bottle fed ☐Nursed ☐ Both

PAST General Emotional Trauma: (check all that apply and note severity: mild, moderate, extreme)

☐Childhood _____ ☐Personal relationship _____ ☐Change of job/career _____
☐School _____ ☐Divorce/separation _____ ☐Change of lifestyle _____
☐Recreational _____ ☐Work related _____ ☐Loss of loved one _____
☐Parent's divorce _____ ☐Commuting _____ ☐Abuse _____
☐Family _____ ☐Financial _____ ☐Stress of being sick/ill _____

Comments: _____

LIFESTYLE PROFILE

How do you grade your emotional/mental health? ☐Excellent ☐Good ☐Fair ☐Poor ☐Getting Better ☐Getting Worse

How do you grade your overall quality of life? ☐Excellent ☐Good ☐Fair ☐Poor ☐Getting Better ☐Getting Worse

Have you pursued other avenues of growth, healing or personal development? (check all that apply and note who you saw, for how long and if you are still going)

☐Chiropractic _____ ☐Acupuncture _____
☐Massage/Bodywork _____ ☐Homeopathy _____
☐Psychotherapy _____ ☐Ayurvedic Medicine _____
☐Osteopathy _____ ☐Physical Therapy _____
☐Aromatherapy _____ ☐Energy Work _____
☐Rebirthing _____ ☐Sound/Light Therapy _____

What aspects of your life please you, bring you joy, and help you to feel better about yourself? _____

What particular factors or elements about your life experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc.:

Do you feel impair your opportunity for full glowing health? _____

Do you feel give you an edge or add to your life and health? _____

Which of the following do you practice regularly (check all that apply and how many times per week)

☐Exercise _____ ☐Yoga _____ ☐Chi Gong/Tai Chi _____ ☐Movement/Dance _____
☐Meditation _____ ☐Prayer _____

List any herbs, nutritional supplements or natural remedies you regularly take: _____

When stressed how do you "center yourself" or "re-group"? _____

Is there anything else you wish to share which may help us better understand you and why you have chosen to come to this office? _____

What type of results would motivate you to tell others about the care you receive in this office, and encourage others to get under care? _____

When communicating with you about your spine, nervous system, health and wellness (circle your preference):

a) Visual Communication- Mostly show me pictures and diagrams.
b) Verbal Communication- Mostly talk to me about the changes I'm making.
c) Kinesthetic Communication- Mostly I need to feel it.

LIFE INTENTION

We are committed to helping you reach and exceed your health and life goals. We know that a true state of Well-Being, one in which you feel alive, vibrant, and fulfilled in all the major areas of your life, is possible for you. If you were living your "Ultimate" life, what would it be like, look like, feel like- Physically, Emotionally, Mentally, Financially, Relationally and Spiritually?

Wellness & Quality of Life Survey

Name: _____ **Date**: _____

Please circle the number that best describes your current experience.

I. Physical State

How often do you experience the following symptoms?

	Never	Rarely	Occasionally	Regularly	Constantly
1. Physical Pain (neck/back ache, sore arms/legs, etc.).	1	2	3	4	5
2. Feeling of tension, stiffness or lack of flexibility.	1	2	3	4	5
3. Fatigue or low energy.	1	2	3	4	5
4. Colds and flu.	1	2	3	4	5
5. Headaches (of any kind).	1	2	3	4	5
6. Heartburn or indigestion.	1	2	3	4	5
7. Nausea or constipation.	1	2	3	4	5
8. Menstrual discomfort.	1	2	3	4	5
8. Allergies or skin rashes.	1	2	3	4	5
9. Dizziness or light-headedness.	1	2	3	4	5
10. Accidents or near accidents or falling or tripping.	1	2	3	4	5
11. Ease of recovery from injury.	1	2	3	4	5
12. Restricted or shallow breathing.	1	2	3	4	5

II. Mental/Emotional State

Rate the following questions with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. If pain is present, how distressed are you about it?	1	2	3	4	5
2. Presence of negative or critical feelings about yourself.	1	2	3	4	5
3. Experience of moodiness, temper or anger outbursts.	1	2	3	4	5
4. Experience of depression or lack of interest.	1	2	3	4	5
5. Over reacting to life's stresses.	1	2	3	4	5
6. Being overly worried about small things.	1	2	3	4	5
7. Experience of vague fears or anxiety.	1	2	3	4	5
8. Difficulty thinking or concentrating or indecisiveness.	1	2	3	4	5
9. Difficulty falling or staying asleep.	1	2	3	4	5
10. Experience of recurring thoughts or dreams.	1	2	3	4	5

III. Stress Evaluation

Evaluate your stress relative to the following:

	None	Slight	Moderate	Considerable	Extensive
1. Family.	1	2	3	4	5
2. Significant Other.	1	2	3	4	5
3. Physical Health.	1	2	3	4	5
4. Finances.	1	2	3	4	5
5. Sex Life.	1	2	3	4	5
6. Work or School.	1	2	3	4	5
7. Coping with daily problems.	1	2	3	4	5

IV. Life Enjoyment

Rate the following statements with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. Openness to guidance from your "inner voice/feelings".	1	2	3	4	5
2. Experience of peace, relaxation, ease or well-being.	1	2	3	4	5
3. Presence of positive feelings about yourself.	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	1	2	3	4	5
5. Feeling of being open, aware and connected when relating to others	1	2	3	4	5
6. Level of confidence in your ability to deal with adversity.	1	2	3	4	5
7. Level of compassion for and acceptance of others.	1	2	3	4	5
8. Experience feelings of joy or happiness.	1	2	3	4	5
9. Experiencing gratitude.	1	2	3	4	5
10. Level of satisfaction with your sex life.	1	2	3	4	5
11. Satisfaction with the level of recreation in your life.	1	2	3	4	5
12. Time devoted to things you enjoy.	1	2	3	4	5

V. Overall Quality of Life

Evaluate your feelings relative to your quality of life:

	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Delighted
1. Your personal life.	1	2	3	4	5
2. Your wife/husband or "significant other".	1	2	3	4	5
3. Your romantic life.	1	2	3	4	5
4. Your job.	1	2	3	4	5
5. Your co-workers.	1	2	3	4	5
6. The actual work you do.	1	2	3	4	5
7. The handling of problems in your life.	1	2	3	4	5
8. What you are actually accomplishing in your life.	1	2	3	4	5
9. Your physical appearance - the way you look.	1	2	3	4	5
10. Your ability to adapt to change in your life.	1	2	3	4	5
11. Overall contentment with your life.	1	2	3	4	5

NETWORK SPINAL ANALYSIS

CONSENT FORM

I hereby request and consent to receiving spinal care, including wellness education in this office by chiropractors who provide **Network Spinal Analysis (NSA) Care**, a low force approach which has unique outcomes and clinical results. These practitioners choose to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This office provides care in accordance with the Council on Chiropractic Practice Guidelines and the Canon of Ethics of the Association for Network Care, and my doctors have been trained in traditional chiropractic care and certified in the procedures of Network Spinal Analysis Care.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. **Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.**

NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts in this office

I am aware that I will be receiving gentle touch Network Adjustments, also called **Entrainments**. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of care, re-assessments will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractors will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to re-organize my spine.

NSA is advanced through a series of Levels of Care. Each level of care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with the greater spinal stability, the re-distribution of energy, and the transfer of internal information are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to NSA care and wellness education, my practitioners may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs.

Please Read and Sign the Following:

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy.

I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes. **This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness.**

Rather than simply attempting to return me to my previous state minus a symptom, these chiropractors instead choose to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity subluxations are corrected. The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to treat any other condition, disease or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I have read, or have had read to me, this CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS (NSA) CARE and **understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.**

_____

PRINTED NAME OF PRACTICE MEMBER

_____ _____

SIGNATURE OF PRACTICE MEMBER DATE

SOMATO RESPIRATORY INTEGRATION (SRI)
Consent Form

Somato Respiratory Integration and Wellness Education* is specifically designed to educate you to your body rhythms and inner wisdom through focused attention, gentle breath, movement, and touch. As a consequence of this heightened awareness, you may have more resources to heal and advance through your **Network Spinal Analysis (NSA)** Care.

You may have had instruction in other self awareness, breathing, movement, and meditation programs, please understand that SRI is different. SRI strengthens your inner connection. With SRI you will experience having the "higher" brain, (the part responsible for consciousness and awareness), focus its attention on a region and/or sensation that was formerly repressed, discarded, denied or desensitized.

This work allows for greater connections between your higher brain and your body, fostering the ability to focus your attention on your body and develop internally customized choices for your body and for your life.

Many of our crises occur when we become "unconscious" of our body, or a region of our body, and take it for granted, or we lose an important element of the interface between body and mind.

Symptoms of all types ask us to pay attention, and that is often the last thing most people are looking to do. Symptoms force us to be in touch with our body, stop our usual routine, do things differently, breathe differently and even at times express emotion or make "foreign" sounds. There is healing in this and wisdom to be gained.

With SRI care you may not need to have severe crises to help you pay better attention to yourself, and with the addition of NSA Care you will have the available tools to do this.

It is easier to make frequent small reassessments and adjustments in life than to have life force you to make a sudden large change. Our intent is to help you develop the somatic habit of consistent spontaneous reassessments, self adjustments, and corrections of your body, its structure and its relationship to your life. In this way you can be more flexible and adaptable to the demands, suggestions, and encouragements in life.

The exercises of the 12 Stages of Healing which produce Somato (body) Respiratory (breath) Integration will be taught during your SRI sessions. These exercises will help you to experience your body more fully with safety and peace.

As a home support program of self-care, they will also further your advancement in NSA Care. It is our experience that these exercises allow you a positive and constructive tool that you can use to deepen the understanding, trust, and well being of your body-mind. In times of symptom crises, SRI will provide you with a method to redirect your body's attention, release tension, and promote greater ease.

Your SRI Wellness Educator will not diagnose, treat, or offer advice on any diseases or symptom. SRI Wellness Education is not specifically about your condition or symptom. It is about you and your available and developing resources.

It is common for self-awareness to heighten during the course of care in the NSA office and during and after SRI sessions. Since you will be learning to pay attention to the body's subtle cues, areas that were "disconnected" from your awareness will awaken their connection.

You may experience physical sensations such as energy, vibration, heat, or at times discomfort. You can discover where you can touch to amplify peace, your inner "nuclear core" of energy and where you store a resource of "chi" (life energy) for your use. You will learn to redirect your body-mind's attention from a distressing circumstance of the moment to inner safety and peace.

During and after some SRI sessions you will likely also be aware of emotional shifts. Sensations may be subtle, or at times very intense, as one experiences greater depth in his/her range of healing stages.

I have read the above Notice of Intent and agree to participate in Somato Respiratory Integration Wellness Education.

I consent to receive SRI Wellness Education, including learning the SRI exercises. I understand that during these sessions I will be touching my body, moving, breathing, and at times verbalizing my experience of my body.

I understand that SRI exercises are not a replacement for any form of medial treatment.

I consent to allow my SRI Wellness Educator to touch me for the purpose of assisting me in learning and refining my experience of these exercises.

I consent to allow my NSA practitioner to release information from my personal and clinical history to my SRI Wellness Educator to share personal and clinical information with my NSA practitioner.

I agree to allow such communication on an ongoing basis so that the exercises and skills I am to learn can be fine-tuned to compliment my circumstance and current NSA Level of Care.

PRINTED NAME OF PRACTICE MEMBER

SIGNATURE OF PRACTICE MEMBER

DATE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Amaral Chiropractic (the "Practice") is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and history as well as the care and treatment you receive from the Practice and other health care providers. This notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment of your care, health care operation of the practice and for other purposes permitted or required by law. This notice also details your rights regarding your PHI.

This Practice employs multiple doctors of Chiropractic and practitioners at any given time. However for purposes of compliance with the Health Information Portability and Accountability Act (HIPAA) Privacy rules, all doctors are deemed to be a part of a single Organized Health Care Arrangement, which means that they operate as an integrated unit; that they will share protected health information in order to carry out chiropractic care (including coverage for each other), payment for services rendered and health care operations; that this notice provided serves as a joint notice made by each doctor, practitioner and staff person and that each of them will abide by the terms of this notice.

This office maintains a sign-in log at the reception area that you are asked to sign before seeing the practitioner. Your name may be seen by others who are in the reception area.

We provide most on-going care in an "open entrainment" area. It is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. This means that statements made by you or employees of the Practice during treatment may be overheard by others. There are various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open entrainment" environment are incidental matters. If you have comments or information you wish to share privately when you come into the entrainment room please inform the doctor or staff and we will accommodate your needs.

In the course of your care at Amaral Chiropractic, we may use or disclose personal and health related information about you in the following ways:

*Your PHI, including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, or your employer if they are responsible for the payment of your services.

*Your name, address, phone number and health care records may be used to correspond with you during or after your care. This may include contacting you regarding: appointment reminders, recommendation notices, birthdays, holiday, referral thank-you's, practice events, or other health related information (ie. Newsletters, e-mails, etc.) that may be of interest to you, as well as other similar correspondence.

Further you have the right to inspect or obtain a copy of the information we will use for these purposes. If you are not at home to receive an appointment reminder call, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. This request must be made in writing. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care to you in an emergency or if we are required by law to provide care and are unable to obtain your consent after attempting to do so.

*If we are ordered by courts or another appropriate agency. Also, when required by law (ie. case of child abuse and neglect) or for special government functions (ie. military, veteran) and correctional institutions in the case of inmates.

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

*If we contract with a business associate to provide a service necessary for your treatment, payment for your services, and health care operations (ie. practice or front desk coverage, billing or transcription service, etc.).

Any use or disclosure of your PHI, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home please advise us in writing.

You have the right to inspect or request a copy of your PHI for seven years from the date the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. The Practice has 30 days to comply. Requests to inspect, copy, or amend your health related information must be made in writing.

We are required by law to maintain the privacy of your patient file and the PHI therein. We are also required to provide you with this notice of our privacy practices with respect to your PHI and to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made we will notify you in writing as soon as possible following the changes.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities please let our staff know.

Your signature indicates your authorization of the policies outline in this notice.

_____

Name (printed)

_____

Signature

_____

Date