

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_/\_\_\_/\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:  Text  Email  Phone - Home, Mobile, or Work  Other: \_\_\_\_\_

\*Referred By: (Name) \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

Race & Ethnicity: (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Decline

Preferred Language:

- English
- Spanish
- Other: \_\_\_\_\_
- Decline

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Relationship:

Child  Parent  Spouse  Other: \_\_\_\_\_

## FINANCIAL INFORMATION

Is today's visit the result of an accident?

No  Auto  Work  Other: \_\_\_\_\_

Will we be working with insurance?  No  Yes (Details)

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

Where would you like statements sent?

Self  Other (Details below)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

Account No: \_\_\_\_\_



# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

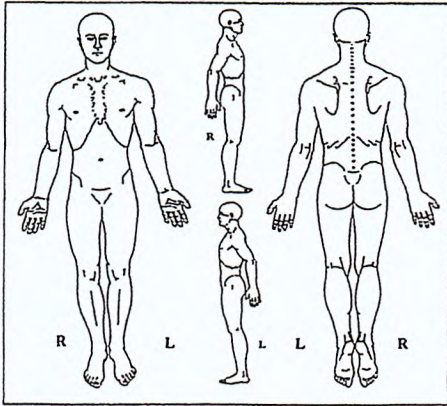
**Major Complaint:** \_\_\_\_\_ **Secondary Complaints:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**When did it start?** \_\_\_ / \_\_\_ / \_\_\_ **What happened?** \_\_\_\_\_  
 \_\_\_\_\_

**Which daily activities are being affected by this condition?** \_\_\_\_\_  
 \_\_\_\_\_

## MAJOR COMPLAINT

### Location of Symptoms and Radiation



P \_\_\_ Pain                      T \_\_\_ Tender  
 N \_\_\_ Numb                    H \_\_\_ Hypoesthesia  
 S \_\_\_ Spasm

**Quality:**

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: \_\_\_\_\_

**Does it radiate?**

- No     Yes *(Please indicate on drawing)*

**Improves with:**

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: \_\_\_\_\_
- Other: \_\_\_\_\_

**Worsens with:**

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: \_\_\_\_\_

**Previous Treatment:**

- None
- Chiropractor \_\_\_\_\_
- Medical Doctor \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- ER/Urgent Care \_\_\_\_\_
- Orthopedic \_\_\_\_\_
- Other: \_\_\_\_\_

**Previous Diagnostic Testing:**

- None
- X-rays \_\_\_\_\_
- MRI \_\_\_\_\_
- CT \_\_\_\_\_
- Other: \_\_\_\_\_

**\*Women: Are you pregnant?**

- No    Last Menstrual Period: \_\_\_ / \_\_\_ / \_\_\_
- Yes                      Due date: \_\_\_ / \_\_\_ / \_\_\_

**Present Illness Comments:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Grade Intensity/Severity:**

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

**Frequency:**

- Off & On
- Constant

**Prescription Medications & Supplements:**     None  
 Yes *(List - Name, dosage, frequency)* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies to Medications:**     No known drug allergies  
 Yes *(List - Name and reaction)* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

**Major Complaint:** \_\_\_\_\_ **Secondary Complaints:** \_\_\_\_\_

\_\_\_\_\_

**When did it start?** \_\_\_ / \_\_\_ / \_\_\_ **What happened?** \_\_\_\_\_

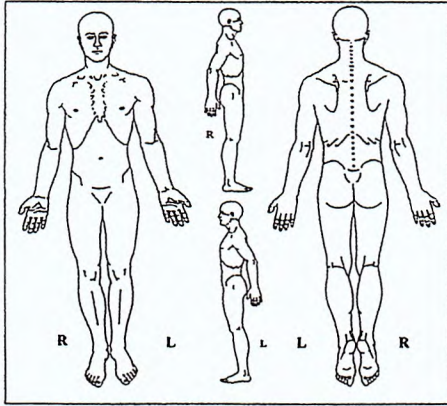
\_\_\_\_\_

**Which daily activities are being affected by this condition?** \_\_\_\_\_

\_\_\_\_\_

## MAJOR COMPLAINT

### *Location of Symptoms and Radiation*



P \_\_\_ Pain                      T \_\_\_ Tender  
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- Orthopedic \_\_\_\_\_
- Other: \_\_\_\_\_

**Previous Diagnostic Testing:**

- None
- X-rays \_\_\_\_\_
- MRI \_\_\_\_\_
- CT \_\_\_\_\_
- Other: \_\_\_\_\_

**\*Women: Are you pregnant?**

- No    Last Menstrual Period: \_\_\_ / \_\_\_ / \_\_\_
- Yes                      Due date: \_\_\_ / \_\_\_ / \_\_\_

*Present Illness Comments:*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prescription Medications & Supplements:**     None

Yes *(List - Name, dosage, frequency)* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies to Medications:**     No known drug allergies

Yes *(List - Name and reaction)* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# PAST, FAMILY, AND SOCIAL HISTORY

**PAST MEDICAL HISTORY**

**Have you ever had any of the following?** (Please select all that apply and use comments to elaborate.)

**Illnesses:**

- Asthma
- Autoimmune Disorder (Type) \_\_\_\_\_
- Blood Clots
- Cancer (Type) \_\_\_\_\_
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: \_\_\_\_\_

**Hospitalizations:** (Non-surgical with Date)

\_\_\_\_\_

\_\_\_\_\_

**Surgeries:** (If yes, provide type & surgery date)

- Cancer \_\_\_\_\_
- Orthopedic
  - Shoulder – R / L \_\_\_\_\_
  - Elbow/Forearm – R / L \_\_\_\_\_
  - Wrist/Hand – R / L \_\_\_\_\_
  - Hip – R / L \_\_\_\_\_
  - Knee – R / L \_\_\_\_\_
  - Ankle/Foot – R / L \_\_\_\_\_
- Spinal Surgery
  - Neck: \_\_\_\_\_
  - Back: \_\_\_\_\_
- Other: \_\_\_\_\_

**Medical History Comments:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Injuries:**

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: \_\_\_\_\_

**FAMILY HISTORY** (Please mark X to all that apply and use comments to elaborate.)

- Unknown     Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

**Family History Comments:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL AND OCCUPATIONAL HISTORY**

**Marital Status:**  Single  Married  Divorced  Other

**Children:**  None  1  2  3  4  Other: \_\_\_\_\_

**Student Status:**  Full Student  Part Student  Non-Student

**Highest level of Education:**  High School  College Grad.

Post Grad.  Other: \_\_\_\_\_

**Employed:**  No  Yes (Occupation) \_\_\_\_\_

**Dominant Hand:**  Right  Left  Ambidextrous

**Smoking/Tobacco Use:** If current smoker, amount = \_\_\_\_\_

- Every Day  Some Days  Former  Never

**Alcohol Use:**

- Every Day  Weekly  Occasionally  Never

**Caffeine Use:**

- Coffee  Tea  Energy Drinks  Soda  Never

**Exercise frequency:**

- Daily  3-4xs/week  2-3xs/week  Rarely  Never

**Social History Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





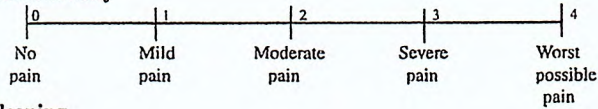


# Functional Rating Index

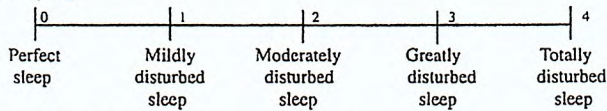
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

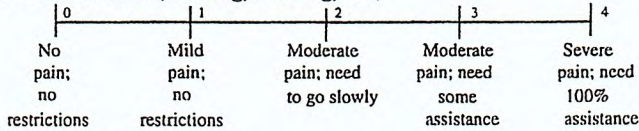
## 1. Pain Intensity



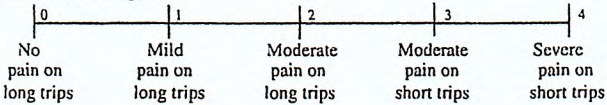
## 2. Sleeping



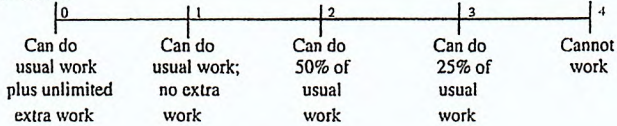
## 3. Personal Care (washing, dressing, etc.)



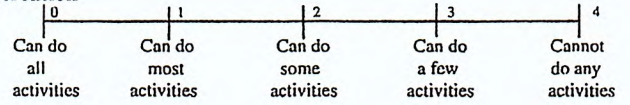
## 4. Travel (driving, etc.)



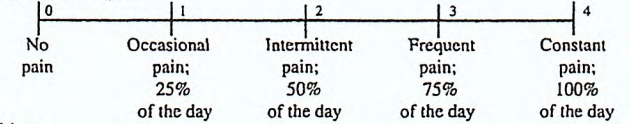
## 5. Work



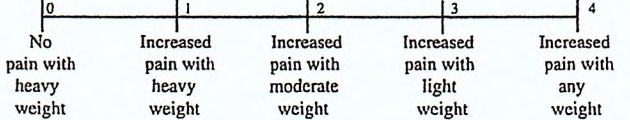
## 6. Recreation



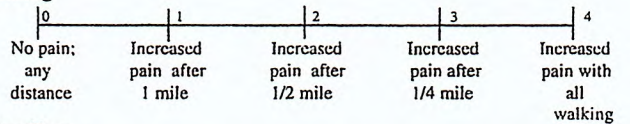
## 7. Frequency of pain



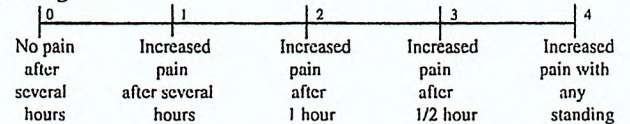
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_ ID#/SS# \_\_\_\_\_ Plan ID \_\_\_\_\_ Total Score \_\_\_\_\_

PRINTED

Signature

Date

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**(Consent to use PHI) Notice of Privacy Practices – Acknowledgment & Consent**

**Acknowledgment for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Hattersley Chiropractic Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the front desk.

**Clinical Summary Report (CCR):**

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Hattersley Chiropractic Clinic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed for me to review.

**Requesting a Restriction the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**I have received a copy of the Notice of Patient Privacy Policy.**

***By my signature below I give my permission to use and disclose my health information.***

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature Date

\_\_\_\_\_  
Print Patient's Full Name Time

\_\_\_\_\_  
Witness Signature Date



## **CONSENT FOR CHIROPRACTIC SERVICES**

**By reading below I have been made aware:**

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms, etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

**Additionally:**

1. I have been afforded ample opportunity for questions and answers.

**Therefore, by signing below:**

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Print Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_



*Notice of Patient Privacy Policy*

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office. Our Privacy Officer is Julla K McNulty

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law 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. You may obtain revisions to our Notice of Privacy Practices by accessing our website [www."Click & Type"](http://www.Click & Type), calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**A. Uses and Disclosures of Protected Health Information**

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, 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. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

**Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent**

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- o **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- o **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care 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. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.
- o **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

For example, we may disclose your protected health information to chiropractic interns or preceptors that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, 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 with that business associate 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 internal 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 will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

**Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization**

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.

- o disclosures of psychotherapy notes
- o uses and disclosures of Protected Health Information for marketing purposes;
- o disclosures that constitute a sale of Protected Health Information;
- o Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the 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 Authorization or Opportunity to Object**

In the following instance where we may use and disclose your protected health information, 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 doctor 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.

- o **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 identify, your protected health information that directly relates to that person's involvement in your health 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 or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. 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 uses and disclosures to family or other individuals involved in your health care.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:



- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.
- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

#### B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.
- Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* 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 be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*
- Your provider is not required to agree to a restriction that you may request. If the doctor 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 doctor 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. With this in mind, please discuss any restriction you wish to request with your doctor.
- You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.
- **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 the request. Please make this request in writing.
- **You may have the right to have your doctor 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. Please contact our Privacy Officer if you have questions about amending your medical record.
- **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. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.
- **You have the right to be notified by our office of any breach of privacy of your Protected Health Information.**

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.

#### Clinical Summary Report(CCR):

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Bowker Clinic of Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed for me to review.

#### C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:*

<http://www.hhs.gov/ncr/riprvacy/hipa/complaints/hipcomplaintform.pdf>

*Or our office can provide you with a written form in which to file your complaint.* You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Julia K McNulty you may contact our Privacy Officer, or any staff member, including Dr. Daniel Bowker at the following phone number 704.541.6400 or our website, at [www.bowkerchiropractic.com](http://www.bowkerchiropractic.com) for further information about the complaint process.

This notice was published and becomes effective on December 19, 2013