Pure Wellness

New Patient Intake Form

Patient Full Name: _____ M F Date of Birth: _____

SSN: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Mobile #: _____ Work #: _____

Email Address: _____ Ethnicity: _____

Preferred Method of Contact: Home # Cell # Email Mail Language: _____

Employer: _____ Work Phone Number: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Marital Status: _____ Referred by: _____

Primary Care Physician: _____

Primary Care Physician Phone: _____ Office Fax: _____

Office Address: _____

Hobbies/Sports: _____

Are you: ☐ Right-handed ☐ Left-handed

In the last two years, have you been involved in a Work-related injury, Personal injury, or Motor Vehicle Accident injury? ☐ YES ☐ NO

Date: _____ Type of Accident: _____

Chief Complaints/Injuries: _____

Have you ever seen a chiropractor before: _____

If you have seen a chiropractor before, how long ago was your last treatment? _____

What is the name of the practice? _____

What condition were you seen for? _____

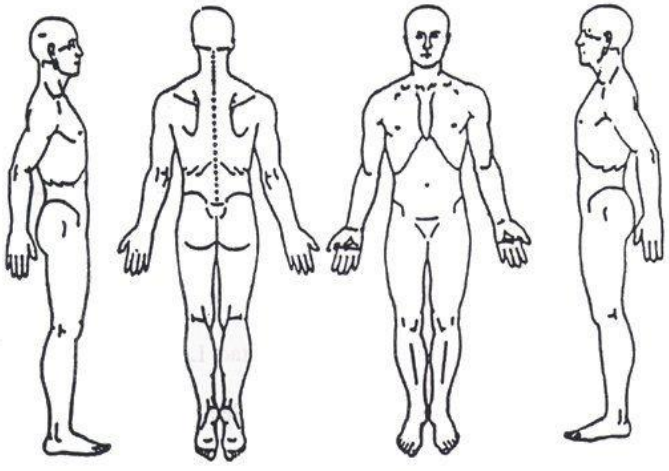
Results from previous treatment: ☐ No Change ☐ Great Improvement ☐ Complete Relief

Are you currently treating with any other doctors for this condition? ☐ YES ☐ NO

Have you had any diagnostic tests done recently? MRI, CAT, X-Ray, EMG? _____

If so, then when? _____

Please indicate on the drawing below, where you have any pain symptoms, in order of severity of pain:



COMPLAINTS: (Check ONE region at a time. For extra areas, please see Second & Tertiary Complaints.) **Primary Complaint: (Your main symptom)**

☐ **Neck**	☐ R ☐ L	☐ **Shoulder**	☐ R ☐ L	☐ **Hand**	☐ R ☐ L	☐ **Ankle**	☐ R ☐ L
☐ **Headaches**	☐ R ☐ L	☐ **Arm**	☐ R ☐ L	☐ **Hip**	☐ R ☐ L	☐ **Foot**	☐ R ☐ L
☐ **Mid Back**	☐ R ☐ L	☐ **Elbow**	☐ R ☐ L	☐ **Leg**	☐ R ☐ L	☐ **Pelvis**	☐ R ☐ L
☐ **Low Back**	☐ R ☐ L	☐ **Wrist**	☐ R ☐ L	☐ **Knee**	☐ R ☐ L	☐ **No Pain**	☐ R ☐ L

1. **When did your problem(s) begin?** Please check or provide exact date. ☐ Immediately after injury
   ☐ The day of the injury ☐ Gradually (few days after injury) ☐ Over the past week
   ☐ Over the past month ☐ Over the past few months ☐ Over the past few years

2. **Does your pain radiate anywhere?** Please Check. ☐ YES ☐ NO Where? _____

3. **How would you describe your pain?** Please check.

☐ Achy	☐ Grabbing	☐ Sore	☐ Throbbing
☐ Burning	☐ Numb	☐ Stabbing	☐ Tightness
☐ Cramping	☐ Sharp	☐ Stiff	☐ Pinching
☐ Dull	☐ Shooting	☐ Tender	☐ Spasming
☐ Tingling	☐ Knotted	☐ Tense	☐ Pulling

4. **How would you rate the severity of your symptoms?** Please check.
   ☐ Minimal ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Mod. To Severe
   ☐ Severe ☐ Debilitating

5. **Using a scale from 0-10 (10 being the worst), how would you rate your problem?** Please circle.
   0 1 2 3 4 5 6 7 8 9 10

6. **Have you experienced these exact or similar symptoms before? If so, when?** ☐ YES ☐ NO
   Explain:

7. **How often do you have pain?** Please check. ☐ Constant ☐ Frequently ☐ Occasional ☐ Off and on

8. **What aggravates your symptoms?** Please check.

☐ Bathing/Dressing	☐ Lifting	☐ Reading	☐ Rising from a chair	☐ Staying still
☐ Bending	☐ Running	☐ Sitting	☐ Going up/down stairs	☐ Sleeping
☐ Computer Work	☐ Looking Up	☐ Standing	☐ Exercise/activity	☐ Yard work
☐ Driving	☐ Reaching	☐ Walking	☐ Other	☐ Weather-changes

9. What alleviates your symptoms? Please check.

☐ Lying down	☐ Sitting	☐ Movement	☐ Medicine/CBD cream
☐ Moist heat	☐ Standing	☐ Sleeping	☐ Chiropractic care
☐ Nothing	☐ Topical creams	☐ Stretching	☐ Exercise/walking
☐ Rest	☐ Ice/Heat	☐ Other	☐ Hot showers

10. Is there a time of day when your pain is at its worst? ☐ No ☐ Morning ☐ As the day progresses ☐ Afternoon ☐ Evening ☐ Bedtime ☐ During the Night ☐ Varies

11. Is there a time of day when you have noticeably less pain? ☐ No ☐ Morning ☐ As the day progresses ☐ Afternoon ☐ Evening ☐ Bedtime ☐ During the Night ☐ Varies

Secondary Complaint (2nd symptom – IF Necessary)

☐ **Neck** ☐ R ☐ L	☐ **Shoulder** ☐ R ☐ L	☐ **Hand** ☐ R ☐ L	☐ **Ankle** ☐ R ☐ L
☐ **Headaches** ☐ R ☐ L	☐ **Arm** ☐ R ☐ L	☐ **Hip** ☐ R ☐ L	☐ **Foot** ☐ R ☐ L
☐ **Mid Back** ☐ R ☐ L	☐ **Elbow** ☐ R ☐ L	☐ **Leg** ☐ R ☐ L	☐ **Pelvis** ☐ R ☐ L
☐ **Low Back** ☐ R ☐ L	☐ **Wrist** ☐ R ☐ L	☐ **Knee** ☐ R ☐ L	☐ **No Pain** ☐ R ☐ L

12. When did your problem(s) begin? Please check or provide exact date. ☐ Immediately after injury ☐ The day of the injury ☐ Gradually (few days after injury) ☐ Over the past week ☐ Over the past month ☐ Over the past few months ☐ Over the past few years

13. Does your pain radiate anywhere? Please Check. ☐ YES ☐ NO Where? _____

14. How would you describe your pain? Please check.

☐ Achy	☐ Grabbing	☐ Sore	☐ Throbbing
☐ Burning	☐ Numb	☐ Stabbing	☐ Tightness
☐ Cramping	☐ Sharp	☐ Stiff	☐ Pinching
☐ Dull	☐ Shooting	☐ Tender	☐ Spasming
☐ Tingling	☐ Knotted	☐ Tense	☐ Pulling

15. How would you rate the severity of your pain? Please check.

☐ Minimal ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Mod. To Severe ☐ Severe ☐ Debilitating

16. Using a scale from 0-10 (10 being the worst), how would you rate your problem? Please circle.

0 1 2 3 4 5 6 7 8 9 10

17. Have you experienced these exact or similar symptoms before? If so, when? ☐ YES ☐ NO

Explain:

18. How often do you have pain? Please check. ☐ Constant ☐ Frequently ☐ Occasional ☐ Off and on

19. What aggravates your symptoms? Please check.

☐ Bathing/Dressing	☐ Lifting	☐ Reading	☐ Rising from a chair	☐ Staying still
☐ Bending	☐ Running	☐ Sitting	☐ Going up/down stairs	☐ Sleeping
☐ Computer Work	☐ Looking Up	☐ Standing	☐ Exercise/activity	☐ Yard work
☐ Driving	☐ Reaching	☐ Walking	☐ Other	☐ Weather-changes

20. What alleviates your symptoms? Please check.

☐ Lying down	☐ Sitting	☐ Movement	☐ Medicine/CBD cream
☐ Moist heat	☐ Standing	☐ Sleeping	☐ Chiropractic care
☐ Nothing	☐ Topical creams	☐ Stretching	☐ Exercise/walking
☐ Rest	☐ Ice/Heat	☐ Other	☐ Hot showers

21. Is there a time of day when your pain is at its worst? ☐ No ☐ Morning ☐ As the day progresses ☐ Afternoon ☐ Evening ☐ Bedtime ☐ During the Night ☐ Varies

22. Is there a time of day when you have noticeably less pain? ☐ No ☐ Morning ☐ As the day ☐ progresses ☐ Afternoon ☐ Evening ☐ Bedtime ☐ During the Night ☐ Varies

Third Complaint (3rd symptom – IF Necessary)

☐ **Neck**	☐ R ☐ L	☐ **Shoulder**	☐ R ☐ L	☐ **Hand**	☐ R ☐ L	☐ **Ankle**	☐ R ☐ L
☐ **Headaches**	☐ R ☐ L	☐ **Arm**	☐ R ☐ L	☐ **Hip**	☐ R ☐ L	☐ **Foot**	☐ R ☐ L
☐ **Mid Back**	☐ R ☐ L	☐ **Elbow**	☐ R ☐ L	☐ **Leg**	☐ R ☐ L	☐ **Pelvis**	☐ R ☐ L
☐ **Low Back**	☐ R ☐ L	☐ **Wrist**	☐ R ☐ L	☐ **Knee**	☐ R ☐ L	☐ **No Pain**	☐ R ☐ L

23. When did your problem(s) begin? Please check or provide exact date. ☐ Immediately after injury ☐ The day of the injury ☐ Gradually (few days after injury) ☐ Over the past week ☐ Over the past month ☐ Over the past few months ☐ Over the past few years

24. Does your pain radiate anywhere? Please Check. ☐ YES ☐ NO Where? _____

25. How would you describe the type of pain? Please check.

☐ Achy	☐ Grabbing	☐ Sore	☐ Throbbing
☐ Burning	☐ Numb	☐ Stabbing	☐ Tightness
☐ Cramping	☐ Sharp	☐ Stiff	☐ Pinching
☐ Dull	☐ Shooting	☐ Tender	☐ Spasming
☐ Tingling	☐ Knotted	☐ Tense	☐ Pulling

26. How would you rank the severity of your pain? Please check.

☐ Minimal ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Mod. To Severe ☐ Severe ☐ Debilitating

27. Using a scale from 0-10 (10 being the worst), how would you rate your problem? Please circle.

0 1 2 3 4 5 6 7 8 9 10

28. How often do you have pain? Please check. ☐Constant ☐Frequently ☐Occasional ☐Off and on

29. Have you experienced these exact or similar symptoms before? If so, when? ☐YES ☐NO

Explain:

30. What aggravates your symptoms? Please check.

☐ Bathing/Dressing	☐ Lifting	☐ Reading	☐ Rising from a chair	☐ Staying still
☐ Bending	☐ Running	☐ Sitting	☐ Going up/down stairs	☐ Sleeping
☐ Computer Work	☐ Looking Up	☐ Standing	☐ Exercise/activity	☐ Yard work
☐ Driving	☐ Reaching	☐ Walking	☐ Other	☐ Weather-changes

31. What alleviates your symptoms? Please check.

☐ Lying down	☐ Sitting	☐ Movement	☐ Medicine/CBD cream
☐ Moist heat	☐ Standing	☐ Sleeping	☐ Chiropractic care
☐ Nothing	☐ Topical creams	☐ Stretching	☐ Exercise/walking
☐ Rest	☐ Ice/Heat	☐ Other	☐ Hot showers

32. Is there a time of day when your pain is at its worst? ☐No ☐ Morning ☐As the day progresses ☐Afternoon ☐ Evening ☐Bedtime ☐During the Night ☐ Varies

33. Is there a time of day when you have noticeably less pain? ☐ No ☐ Morning ☐ As the day ☐ progresses ☐ Afternoon ☐Evening ☐ Bedtime ☐ During the Night ☐ Varies

New Patient Background

Age: _____ Race/Ethnicity: _____ Height: _____ ft. _____ in.

Weight: _____ lbs. Occupation: _____

Exercise: ☐ YES ☐NO Do you smoke: ☐ YES ☐NO _____ packs per day

Do you consume alcohol? ☐ YES ☐ NO ☐ Socially ☐ Occasionally ☐ Frequently ☐ Daily

Have you had any of the following treatments in the past? What was done, when and how effective?

Please circle your level of relief.

1. Anti-inflammatories: Type _____ com. Relief great imp. min imp. no imp.
2. Muscle relaxors: Type _____ com. Relief great imp. min imp. no imp.
3. Pain medications: Type _____ com. Relief great imp. min imp. no imp.
4. Physical therapy: Type _____ com. Relief great imp. min imp. no imp.
5. Surgeries: _____ com. Relief great imp. min imp. no imp.
6. Chiropractic care: When? _____ com. Relief great imp. min imp. no imp.

7. **For each of the conditions listed below, please put a check mark in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present		Past	Present		Past	Present	
___	___	Headaches	___	___	Dizzines	___	___	Diabetes
___	___	Neck Pain	___	___	High Blood Pressure	___	___	Excessive Thirst
___	___	Upper Back Pain	___	___	Heart Attack	___	___	Frequent Urination
___	___	Mid Back Pain	___	___	Chest Pains	___	___	Smoking/Tobacco
___	___	Low Back Pain	___	___	Stroke	___	___	Drug/Alcohol Dependence
___	___	Shoulder Pain	___	___	Angina	___	___	Allergies
___	___	Elbow/Upper Arm Pain	___	___	Kidney Stones	___	___	Depression
___	___	Wrist Pain	___	___	Kidney Disorders	___	___	Systemic Lupus
___	___	Hand Pain	___	___	Bladder Infection	___	___	Epilepsy
___	___	Hip Pain	___	___	Painful Urination	___	___	Dermatitis
___	___	Upper Leg Pain	___	___	Loss of Bladder Control	___	___	Eczema/Rash
___	___	Knee Pain	___	___	Prostate Problems	___	___	HIV/AIDS
___	___	Chronic Sinusitis	___	___	Abnormal Wt. Gain/Loss	___	___	Asthma
___	___	Ankle/Foot Pain	___	___	Loss of Appetite			**FOR FEMALES ONLY**
___	___	Jaw Pain	___	___	Abdonimal Pain	___	___	Birth Control
___	___	Joint Pain/Stiffness	___	___	Ulcer	___	___	Hormone Therapy
___	___	Arthritis	___	___	Hepatitis	___	___	Pregnancy
___	___	Rheumatoid Arthritis	___	___	Liver/Gallbladder Disorder	___	___	Dysmenorrhea
___	___	General Fatigue	___	___	Cancer	___	___	Endometriosis
___	___	Visual Disturbances	___	___	Tumor	___	___	Menopause

Please list all prescription or over-the-counter medications that you are currently taking.

Please list all of the supplements that you are currently taking.

Please list all of the surgical prcedures that you have had.

Do you have any history of the following health problems/conditions in your family? Please circle.

Respiratory disease	Mother	Father	Grandmother	Grandfather
Hypertension (high blood pressure)	Mother	Father	Grandmother	Grandfather
Gastro-Intestinal disease	Mother	Father	Grandmother	Grandfather
Diabetes	Mother	Father	Grandmother	Grandfather
Skin Disease	Mother	Father	Grandmother	Grandfather
Neurological disease	Mother	Father	Grandmother	Grandfather
Arthritis	Mother	Father	Grandmother	Grandfather
Stroke	Mother	Father	Grandmother	Grandfather
Cancer (type)	Mother	Father	Grandmother	Grandfather
Heart Disease	Mother	Father	Grandmother	Grandfather

Have you ever been hospitalized? Please Check. ☐ YES ☐ NO

If so, for what, and when? _____

Have you had any significant past trauma? Please Check. ☐ YES ☐ NO

If so, when? _____

Any other pertinent information that you need to share with us? _____

Welcome to Pure Wellness and thank you for trusting us with your care!

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

Pure Wellness
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Acupuncture • Massage
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4608 S. Dupont Hwy
Unit 3
Dover, DE. 19901
T : 302-216-6116
F : 302-261-7377

Physicians

Eric Marks, D.C.
Ken Decker, D.C
Joelle Renaud, D.C., ICCSP
Jessica Cortellino, D.C.
Todd Richardson, D.C.
Brenda Fairchild, D.C., CACCP
Michael Giambertone, D.C.
Rebecca Leary, D.C.
Justin Dietrich, D.C.
Mark Mauragas, D.C.
Justin Johnson, D.C.
Vivian Giannakakis, D.C.
Christopher Schellinger, D.C.
Brooke Mazujian, D.C.

Services

Chiropractic
Acupuncture
Massage Therapy
Functional Medicine

Newark Hours

Monday: 8-1; 3-6:30
Tuesday: 8-1; 3-6
Wednesday: 8-1; 3-6:30
Thursday: 8-1; 3-6
Friday: 8-1; 2:30-5
Saturday: 8-2

Smyrna Hours

Monday: 8:30-1; 2:30-6
Tuesday: 8:30-1; 2:30-6
Wednesday: 8:30-1; 2:30-6
Thursday: 8:30-1; 2:30-6
Friday: 8:30-1

Wilmington Hours

Monday: 11-7
Tuesday 7:30-12:30
Wednesday: 9-1; 2-7
Thursday: 9-1; 2-7
Friday: 7:30-12:30

Middletown Hours

Monday: 8:00-1; 2-6
Tuesday: 8:30-12
Wednesday: 8:00-1; 2-6
Thursday: 8:30-12;2-6
Friday: 8:00-1
Saturday: By Appt Only

Camden Hours

Monday: 8:30-1; 2:30-5:30
Tuesday: 8:30-1; 2:30-5:30
Wednesday: 8:30-1; 2:30-5:30
Thursday: 8:30-1; 2:30-5:30
Friday: 8:30-1

Cancellation/No Show Policy

Our goal is to render excellent care in a timely manner. In order to do so, we have implemented an Appointment/Cancellation Policy that allows us to schedule appointments for all patients in need of care. When an appointment is scheduled, that time has been set aside, and if it is missed, that appointment may not be used for another patient in need of treatment.

Cancellation for Doctor Appointment

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment that you provide at least 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to another person.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $35 cancellation fee.

The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Scheduled Appointments

We understand that delays may occur; however to be respectful of doctors and others patients time, if a patient is 15 minutes past their scheduled time we may need to reschedule the appointment.

Our practice firmly believes that good relationships are based upon understanding an deep communication. Please let our staff know if you have any questions regarding this policy.

_____ _____
PATIENT NAME DATE

_____ _____
PATIENT SIGNATURE WITNESS

Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance

Patient's Name:_____
Employer: _____
Claim/Group: _____
SS# or ID#: _____

I hereby authorize and direct payment for services rendered to me to be made payable to **Pure Wellness**.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

I understand that it is my responsibility to know my benefits and I understand that Pure Wellness will act on my behalf to obtain payment for services rendered to me.

I understand that it is my decision to receive treatment based on the recommendations of the doctor, and I understand that my insurance company may or may not approve all medically necessary treatments. I understand that I am financially responsible for all charges whether or not paid/authorized by my insurance carrier.

I understand that I am responsible for obtaining any authorizations or referrals for services provided. Failure to do so may result in my being financially responsible for services rendered.

I understand that most health insurance plans DO NOT COVER supplies, supports, vitamins and massage, acupuncture, etc. Such items must be paid for at the time service or upon receipt of the supplies.

I understand that I am responsible to provide PURE WELLNESS with any changes in my health care coverage, my current condition or my personal information. (ex: name change, address, phone#, etc.)

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Pure Wellness will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Pure Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care that any fees for professional services rendered to me will be due and payable within 30 days.

I authorize the use of my signature on all insurance submissions.

A photocopy of this assignment shall be considered as effective and valid as original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at Pure Wellness this _____ day of _____of 20____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant if other than policyholder

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

The 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 or required by law. It also describes your rights to access and control your protected health information (PHI). "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your PHI 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. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or your PHI 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.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or other pre-certifications of services may require that your relevant health care information be disclosed to a health plan.

Health Care Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the reception area. We may also disclose your PHI to contact you to remind you of your appointment.

Permitted and Required Uses and Disclosures

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military and national security activities, worker's compensation., inmates. Under the law, we must make disclosures to you 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. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to copy and inspect your protected health information. 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 PHI that is subject to law that prohibits access to PHI.

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 PHI for the purpose of treatment, payment or health care operations. You may also request that any part of your PHI 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 physician is not required to agree to the requested restriction. If the physician believes that it is not in your best interest, your PHI will not be restricted. You then have the right to use another health care practitioner.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You also have the right to receive a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. 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 also have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

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. We will not retaliate against you for filing a complaint.

We have the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please feel free to contact us in person or by phone.

Signature below is only acknowledgment that you have received our Notice of Privacy Practices.

Signature _____ Print Name _____ Date _____