Alternative Health Care

Angela Baxter, LLC
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Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name:_____ **MI:** ____ **Last Name:**_____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Contact Phone: _____ **Is this:** ☐ **cell** ☐ **home** ☐ **work**

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone

DOB: ___/___/____ **Gender (Circle one):** Male / Female

Social Security# _____ **Marital Status:** _____

Employer: _____ **Occupation:** _____

Emergency Contact Name: _____ **Phone:** _____

Referred by: _____

The Following Questions are Government Mandated

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White(Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any allergies to medications?

Medication Name	Reaction	Onset Date	Additional Comments

Current Complaints:

Nature of Injury: ☐ Automobile* ☐ Work** ☐ Other

*Please only select automobile if filing a claim with auto insurance

**Please only select work if filing for workers compensation

Please Describe Injury:

_____

Date of Injury: _____ Date of Symptoms: _____

Have you ever had the same condition: ☐ No ☐ Yes; if yes, when: _____

List any practitioners that have seen you're for this injury:

_____

Have you ever been under chiropractic care? ☐ No ☐ Yes; if yes, when and why: _____

Primary Care Physician:

Name of Doctor: _____

Address: _____

I give permission to contact my primary care physician: ☐ No ☐ Yes

Insurance Information:

Name of Party Responsible: _____

What Type of Insurance: ☐ Auto Insurance ☐ Worker's Compensation ☐ Health Insurance

Name of Company: _____

If Auto/Work Comp, what is the claim #: _____

Contact Name and Phone #: _____

☐ **I choose to receive a copy of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)* ***Starting January 1, 2013***

Patient Name: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional series rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____

Guardian's Signature if Patient is under the age of 18: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Health History Form

Patient Name: _____

Medical History:

Have you been treated for any conditions in this last year? ▫ No ▫ Yes

If yes, please describe: _____

Date of last physical: _____ Are you pregnant? ▫ No ▫ Yes

Have you had x-rays taken recently? ▫ No ▫ Yes

If yes, when and where? _____

Have you ever:

Broken Bones? ▫No ▫Yes Describe: _____

Been Hospitalized? ▫No ▫Yes Describe: _____

Been in an Auto Accident? ▫No ▫Yes Describe: _____

Had Sprains/Strains? ▫No ▫Yes Describe: _____

Been Struck Unconscious? ▫No ▫Yes Describe: _____

Had Surgery? ▫No ▫Yes Describe: _____

▫ Alcoholism	▫ Allergies	▫ Anemia	▫ Arteriosclerosis	▫ Arthritis
▫ Asthma	▫ Back Pain	▫ Breast Lump	▫ Bronchitis	▫ Bruise Easily
▫ Cancer	▫ Chest Pain/Conditions	▫ Cold Extremities	▫ Cramps	▫ Depression
▫ Diabetes	▫ Digestion Problems	▫ Dizziness	▫ Ears Ring	▫ Excessive Menstruation
▫ Eye Pain/Difficulties	▫ Fatigue	▫ Frequent Urination	▫ Headache	▫ Hemorrhoids
▫ High Blood Pressure	▫ Hot Flashes	▫ Irregular Heart Beat	▫ Irregular Cycle	▫ Kidney Infection
▫ Kidney Stones	▫ Loss of Memory	▫ Loss of Balance	▫ Loss of Smell	▫ Loss of Taste
▫ Neck Pain/Stiffness	▫ Nervousness	▫ Nosebleeds	▫ Pacemaker	▫ Polio
▫ Poor Posture	▫ Prostate Trouble	▫ Sciatica	▫ Shortness of Breath	▫ Sinus Infection
▫ Sleep Problems/Insomnia	▫ Spinal Curvatures	▫ Stroke	▫ Swollen Ankles	▫ Swollen Joints
▫ Thyroid Conditions	▫ Tuberculosis	▫ Ulcers	▫ Varicose Veins	▫ Venereal Disease

▫ Other: _____

Habits:

Alcohol ▫ None ▫ Light ▫ Moderate ▫Heavy
Tobacco ▫ None ▫ Light ▫ Moderate ▫Heavy
Exercise ▫ None ▫ Light ▫ Moderate ▫Heavy
Appetite ▫ None ▫ Light ▫ Moderate ▫Heavy
Water ▫ None ▫ Light ▫ Moderate ▫Heavy
Sugary Foods ▫ None ▫ Light ▫ Moderate ▫Heavy

Coffee ▫ None ▫ Light ▫ Moderate ▫Heavy
Drugs ▫ None ▫ Light ▫ Moderate ▫Heavy
Sleep ▫ None ▫ Light ▫ Moderate ▫Heavy
Soft Drinks ▫ None ▫ Light ▫ Moderate ▫Heavy
Salty Foods ▫ None ▫ Light ▫ Moderate ▫Heavy
Artificial Sweeteners ▫ None ▫ Light ▫ Moderate ▫Heavy

Do you experience pain every day? ▫ No ▫ Yes
Do your symptoms interfere with daily life? ▫ No ▫ Yes
Does pain wake you up at night? ▫ No ▫ Yes
Are your symptoms worse during certain times of the day? ▫ No ▫ Yes
Do changes in weather affect your symptoms? ▫ No ▫ Yes
Do you wear orthotics? ▫ No ▫ Yes
What activities aggravate your symptoms? _____

Patient Signature: _____ **Date:** _____

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their physician before they start becoming more physically active. ***Please complete this form as accurately and completely as possible.***

PAR-Q FORM Please mark YES or NO to the following:	YES	NO
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	___	___
Do you frequently have pains in your chest when you perform physical activity?	___	___
Have you had chest pain when you were not doing physical activity?	___	___
Have you had a stroke?	___	___
Do you lose your balance due to dizziness or do you ever lose consciousness?	___	___
Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?	___	___
Are you pregnant now or have given birth within the last 6 months?	___	___
Do you have asthma or exercise induced asthma?	___	___
Do you have low blood sugar levels (hypoglycemia)?	___	___
Do you have diabetes?	___	___
Have you had a recent surgery?	___	___

If you have marked YES to any of the above please elaborate below

_____

_____

_____

Do you take any medications, either prescription or non-prescription, on a regular basis? YES / NO

What is the medication for? _____

How does the medication affect your ability to exercise or achieve your fitness goals?

_____

_____

Please note: If your health changes such that you could then answer YES to any of the above questions, tell your trainer/coach. Ask whether you should change your physical activity plan.

I have read, understood, and completed the questionnaire. Any questions I had were answered to my full satisfaction.

Print Name: _____ Signature: _____

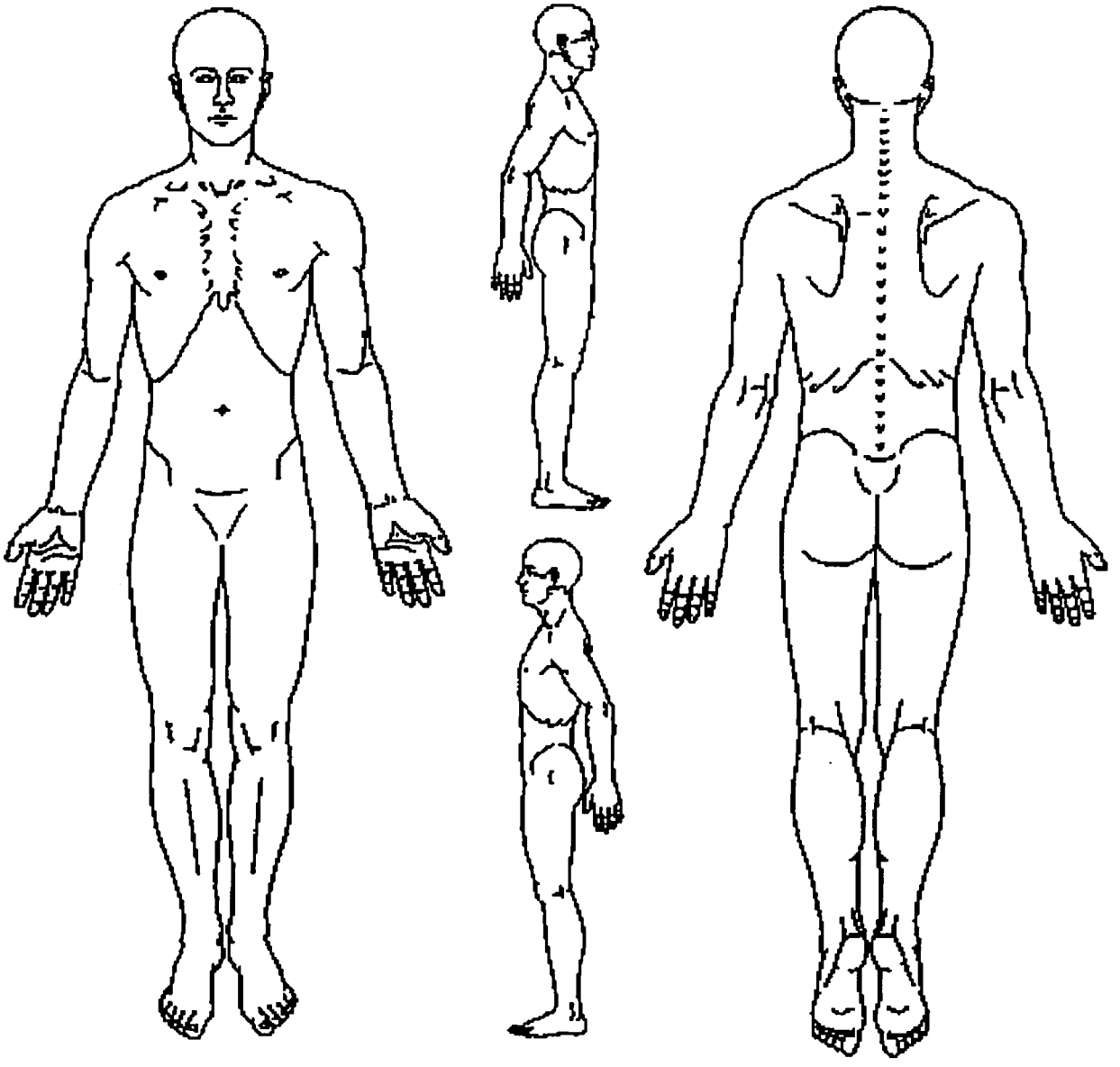
Date: _____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE B = BURNING N = NUMBNESS
P = PINS & NEEDLES S = STABBING O = OTHER

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

HEADACHE DISABILITY INDEX

Patient Name: _____ **Date:** _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headaches: (1) 1 Per month (2) More then 1 but less than 4 per month (3) More than one per week
2. My headaches are: (1) Mild (2) Moderate (3) Severe

Please Read Carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
			E1	Because of my headaches I feel handicapped.
			E2	Because of my headaches I feel restricted in performing my routine daily activities.
			E3	No one understands the effect my headaches have on my life.
			E4	I restrict my recreational activities (eg. Sports, Hobbies) because of my headaches.
			E5	My headaches make me angry.
			E6	Sometimes I feel that I am going to lose control because of my headaches.
			E7	Because of my headaches I am less likely to socialize.
			E8	My Spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
			E9	My headaches are so bad that I feel that feel that I am going to go insane.
			E10	My outlook on the world is affected by my headaches.
			E11	I am afraid to go outside when I feel that a headache is starting.
			E12	I feel desperate because of my headaches.
			E13	I am concerned that I am paying penalties at work or at home because of my headaches.
			E14	My headaches place stress on my relationships with family or friends.
			E15	I avoid being around people when I have a headache.
			E16	I believe my headaches are making it difficult for me to achieve my goals in life.
			E17	I am unable to think clearly because of my headaches.
			E18	I get tense (eg. Muscle tension) because of my headaches.
			E19	I do not enjoy social gatherings because of my headaches.
			E20	I feel irritable because of my headaches.
			E21	I avoid traveling because of my headaches.
			E22	My headaches make me feel confused.
			E23	My headaches make me feel frustrated.
			E24	I find it difficult to read because of my headaches.
			E25	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

_____

Examiner: _____

_____

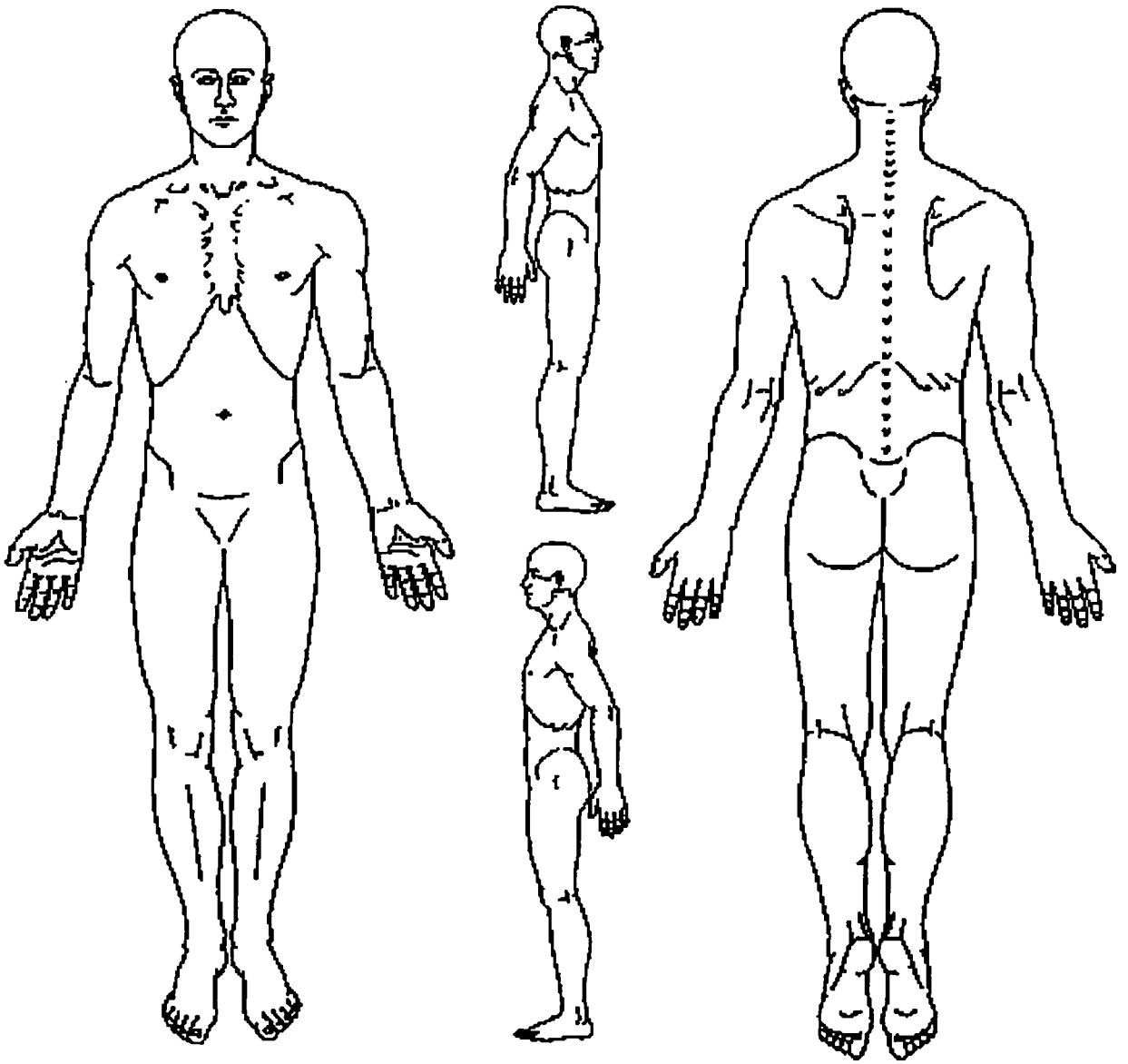
With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI).* Neurology 1994: 44:837-842

THE NECK DISABILITY INDEX QUESTIONNAIRE

NAME _____ DATE _____

How long have you had neck pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE B = BURNING N = NUMBNESS
P = PINS & NEEDLES S = STABBING O = OTHER

OVER PLEASE ⇒

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (___Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Appointment Policy

Through your patient education we know that you recognize the importance of **time** and **frequency** as two of the most important factors in your treatment program. Therefore, following your recommendations is vital to your overall health and wellness. Your recommendations have been made specifically for you – it is imperative that you follow the recommendations as given – this means making your necessary appointments and rescheduling if needed. Lack of consistency to your prescribed program can and will result in a lack of long-term success with your health goals. Your Re-Exam is an excellent time to bring to light any questions or concerns that you may have regarding your care here.

This agreement assumes your full cooperation as a patient here. This cooperation includes your agreement to remain active in your recommended treatment program.

MISSING OR CHANGING APPOINTMENTS

Our staff will help you in following a treatment plan that is designed especially for you. To succeed in gaining positive results, it is imperative that we follow this plan and maintain the number of scheduled visits each week. If you are unable to keep your appointment(s) on any given day, please notify our office at least 24 hours prior to the scheduled appointment. If you must miss an appointment, we will reschedule you for your make-up appointment within a week. If you fail to provide proper notice, you will be charged a $15.00 cancellation fee. This will be added to your account and you will be responsible to provide payment on your next visit. Only in a case of emergency and with the director's approval, will any cancellation fees be forgiven.

_____ _____

Patient Signature Date

ALTERNATIVE HEALTH CARE AND WELLNESS CENTER, LTD.

Effective Date: September 23, 2013

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and/or disclose your protected health information ("PHI") to carry out treatment, payment, or health care operations and for other purposes required by law. It also describes your rights to access and control any PHI that we have about you. PHI is information about you, including demographic, that may identify you and that relates to your past, present, or future physical or mental health and related services.

We are required, by law, to maintain the privacy of PHI and provide individuals with notice of our legal duties and privacy practices with respect to such information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of this Notice. The new notice provisions will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with a paper copy of any revised Notice of Privacy Practices by mail or at the time of your appointment, even if you agreed to receive the Notice of Privacy Practices electronically.

Permitted Use & Disclosure of Your Protected Health Information ("PHI"):

Your physician, office staff, and others outside the office that are involved in your care may use and/or disclose your PHI for the purpose of providing health care services to you. We have listed some of the reasons why we might use or disclose your PHI and some examples of the types of uses or disclosures below. Not every use or disclosure is listed, but all of the ways that we are permitted to use and disclose information will fall into one of the following categories.

Treatment: We will use and disclose your PHI to provide and coordinate your health care and any related services. This includes the coordination or management of care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a health agency that provides care to you. In addition, we may disclose your PHI to another health care provider (e.g., a specialist or laboratory) who, at the request of your physician, is involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: We may use and disclose your PHI for billing and payment of the treatment that you received here. For example, we may use or disclose your PHI to your insurance company about a service you received so that your insurance company can pay us or reimburse you for the service. We may also ask your insurance company for prior authorization for a service to determine whether the insurance company will cover that service.

Health Care Operations: We may use and disclose your PHI to support the business activities of (Add Practice Name). These activities may include, but are not limited to, business activities, quality assessment activities, marketing, fundraising, research and the sale, transfer, merger, or consolidation of all or part of our office, related due diligence as required by law, and employee review activities. Certain direct or indirect exchanges of your PHI may result in remuneration, financial or otherwise. For example, we may use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician. We may also call you by name in the reception when your physician is ready to see you. We may use your PHI to contact you (i.e. by telephone and/or mail) to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you or as required in the event that your PHI has been compromised.

We will share your PHI with third party "business associates" that assist in practice activities, such as billing. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We are prohibited from using or disclosing your genetic information for underwriting purposes, however, limited exceptions for long-term care underwriting purposes may apply.

Use & Disclosure of Your Protected Health Information ("PHI") that Requires Your Written Authorization:

You have the opportunity to agree or object to the use or disclosure of all or part of your PHI.

Your Rights: You have the right to request restrictions on certain uses and/or disclosures of your PHI. You may ask us not to use and/or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may request that information about your care be withheld from your health plan if you pay for your care out-of-pocket and in full. Please discuss any restriction you wish to request with your physician.

You may request an amendment to the use or disclosure of the PHI. Your physician may, using his/her professional judgment, determine whether the disclosure is in your best interest. If your request for an amendment is denied, 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. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. Requested amendments and rebuttals may be placed in your medical records.

You have the right to inspect and copy your PHI. 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. In some circumstances, you may have a right to have this decision reviewed.

You have the right to receive an accounting of the specific information regarding the disclosures of your PHI that occurred after April 14, 2013. 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, a facility directory, to family members or friends involved in your care, for notification purposes, or disclosures you have authorized. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Other uses and disclosures of your PHI 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 (Add Practice Name) has taken an action in reliance on the use or disclosure indicated in the authorization.

In the event that you need to file a complaint regarding the use and/or disclosure of your PHI or if you have any questions about the content of this Notice of Privacy Practices, or if you need to contact us about any of the information contained in this Notice of Privacy Practices, the Privacy Contact Person is:

Primary: _____

Secondary: _____

Address

Phone

You may file a complaint with us or to the Secretary of the United Stated Department 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 Person of your complaint. We will not retaliate against you for filing a complaint.

All requests for reviews, restrictions, amendments, and alternative communications means or locations, must be in writing and state the specific requested action and name any applicable persons for which the request may pertain.

We may use and disclose your PHI in the following instances:

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Others Involved in Your Healthcare: We may disclose to a family member or friend that you identify, your PHI that directly relates to that person's involvement in your health care. We may use or disclose your PHI to notify or assist in notifying such persons of your location, general condition or death. We may disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to persons involved in your health care. For any persons you have identified for notification purposes as described in this Notice of Privacy Practices, you may request that any part of your PHI not be disclosed to that individual.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. We may use or disclose your PHI if your physician or another physician at (Add Practice Name) is required by law to treat you and the physician has attempted to obtain your consent but is unable to do so due to substantial communication barriers, and the physician determines, using his/her professional judgment, that under the circumstances it is your intent to consent to the physician's use or disclosure or your PHI.

Psychotherapy notes (if applicable): We may use and/or disclose your psychotherapy notes for treatment, payment, or health care operations; for training purposes within our office; and as legally allowed and/or required by law.

Uses & Disclosures That Do Not Require Your Consent, Authorization or Opportunity to Object:

We may use or disclose your PHI in the following situations without your consent or authorization.

Required By Law: We may use and/or disclose your PHI to the extent that 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. We may disclose your PHI in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority 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 PHI, 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 PHI, 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: Oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. We may disclose your PHI to a health oversight agency for activities such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI 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.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Law Enforcement: We may also disclose your PHI for law enforcement purposes. Law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) information as it pertains 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, (6) in a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred, and (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, Funeral Directors, and Organ Donation: We may disclose your PHI to a coroner or medical examiner for identification purposes, for determining cause of death or for the coroner or medical examiner to perform other duties. We may also disclose PHI to a funeral director in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaver, organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Military Activity and National Security: We may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for a determination by the Department of Veterans Affairs of eligibility for benefits, or (3) to foreign military authority if a member of that foreign military services. We may also disclose PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Data Security: Patient records are maintained on paper charts. The charts are secured in locked cabinets with limited access. We are required to notify affected individuals following a breach of secured PHI.

ALTERNATIVE HEALTH CARE AND WELLNESS CENTER

Effective Date: September 23, 2013

NOTICE OF PRIVACY PRACTICES

I, _____, have read the attached Notice of Privacy Practices and authorize Alternative Health Care and Wellness Center to disclose the identified information to the persons and for the purpose described herein. I understand that, by signing this document, I release Alternative Health Care and Wellness Center from any liability and will hold Alternative Health Care and Wellness Center harmless for any release made pursuant to this Authorization.

_____ _____

Signature of Patient or Legal Representative Date

_____

Description of Legal Representative's Authority