New Patient Information Form

After you have finished completing this, please bring it up to the front desk *along with your current insurance card(s)*, if applicable.

Name: _____
First Middle Initial Last

Address: _____
Street Number & Name Apartment #

_____
City State Zip

Preferred Language: ☐ English ☐ Spanish Other: _____

Race/Ethnicity: check all that apply

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other race

Date of Birth: _____ Social Security # _____

Occupation: _____ Employer: _____

Please check the number you prefer to be contacted by. Thank you!

☐ Home Phone #: _____ ☐ Cell Phone #: _____
Area Code Number Area Code Number

☐ Work Phone #: _____
Area Code Number Extension

Email: _____

Name of Person to contact in case of emergency:

_____ _____
Relationship

Phone number: (____) _____
Area Code Number Extension

Referred by: _____

Previous Chiropractic Care: ☐ Date of last care: _____

Current Medications/Supplements:

Allergies: Yes ☐ No ☐ **Describe Reaction:**

Smoking Status: (Age13 and over)
Current Every Day Smoker: ☐ Current Some Days Smoker: ☐ Former Smoker: ☐
Never Smoked: ☐

Your answers to these questions will help us to have a more effective and productive visit. Please let me know the best way to help you in our time together.

What is our focus today? Please list in priority order the topics or questions you wish to cover today.

1.

2.

If you have other topics you would like to address, it may require that we schedule more time during our next appointment.

1.

2.

When did the pain start? _____ Have you had this in the past?_____

Has any home treatment improved this? _____ What? _____

Pain in worse when I… Work:☐ Walk:☐ Lift:☐ Bend:☐Stand:☐ Sit:☐ Lie Down: ☐

This is… Constant On and off List any treatments received for present complaint: _____

_____

Name of treating Doctor: _____ Diagnosis: _____

Number of times in the last two weeks you exercised and what it was: _____

List any operations and the years they occurred: _____

_____

Primary Medical Doctor or Clinic: _____

Date of last physical exam:_____ Any significant findings?_____

Have you been diagnosed with high blood pressure? ☐Yes ☐No

Have you been in an auto accident in the … Past year:☐ Past 5 years:☐ Over 5 years:☐

List any significant injuries due to an auto accident: _____

List any other significant injuries (childhood or adult) you have had: _____

_____

Do you sleep mainly on your: Stomach:☐ Back:☐ Side:☐

Have you ever: (briefly describe)

Been knocked unconscious? _____

Had a fractured bone? _____

Been hospitalized other than surgery? _____

Past and present health problems of: Parents, grandparents, brothers, and sisters.
(Diabetes, cancer, heart attacks, strokes, high blood pressure, etc.)
Relationship:

_____

_____

_____

Please mark X for all your present symptoms and O for all your past symptoms:

Head:
_____Headache
_____Sinus (allergy)
_____Entire head
_____Back of head
_____Forehead
_____Temples
_____Migraine
_____Loss of memory
_____Light headedness
_____Fainting
_____Blurred vision
_____Double vision
_____Loss of vision
_____Pain in ears
_____Ear noises
_____Convulsions

Muscles and Joints:
_____Arthritis
_____Bursitis
_____Hernia
Pain or numbness in:
_____Shoulders
_____Arms
_____Elbows
_____Hands
_____Hips
_____Legs
_____Knees
_____Ankles
_____Feet
_____Spinal curvature
_____Swollen joints
_____Herniated/ruptured disc
_____Muscle spasms

Gastrointestinal:
_____Belching or gas
_____Colon disease
_____Constipation
_____Diarrhea
_____Gall bladder (disease/stones)
_____Hemorrhoids
_____Jaundice
_____Liver trouble
_____Nausea
_____Stomach pain
_____Vomiting

Genito Urinary:
_____Blood in urine
_____Frequent urination
_____Inability to control bladder
_____Painful urination
_____Kidney infection/stones
_____Prostate trouble
_____Bladder infection

Cardio Vascular:
_____Hardening of arteries
_____High blood pressure
_____Low blood pressure
_____Poor circulation
_____Rapid heart beat
_____Slow heart beat
_____Heart disease

Respiratory:
_____Chest pain
_____Asthma/wheezing
_____Chronic cough
_____Difficulty breathing
_____Spitting up blood
_____Spitting up phlegm

Skin:
_____Boils
_____Bruise easily
_____Dryness
_____Hives or allergy
_____Itching

General:
_____Nervousness
_____Irritable
_____Depression
_____Fatigue
_____Generally run down
_____Loss of sleep
_____hours per night
_____Loss of weight
_____lbs.
_____Gain of weight
_____lbs.

Diseases/Conditions:
_____AIDS
_____Alcoholism
_____Anemia
_____Appendicitis
_____Cancer
_____Cyst
_____Diabetes
_____Emphysema
_____Epilepsy
_____Goiter
_____Gout
_____Hyperthyroidism
_____Hypothyroidism
_____Measles
_____Mumps
_____Pleurisy
_____Pneumonia
_____Polio
_____Rheumatic fever
_____Scarlet fever
_____Stroke
_____Tuberculosis
_____Ulcers
_____Whooping cough

For Women only:
_____Cramps or backache
_____Menopausal symptoms
_____Excessive menstrual flow
_____Irregular cycle
_____Miscarriage
_____Pregnant now

_____ _____
Signature of Patient or Guardian if under 18 Date

Functional Rating Index

In order to properly assess your condition, we must understand how much your condition has 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**

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. **Sleeping**

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	No Sleep

3. **Personal care** (washing, dressing, etc.)

0	1	2	3	4
No pain	Mild pain	Moderate pain	Moderate pain	Severe pain

4. **Travel** (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. **Work**

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work but no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. **Recreation**

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do few activities	Cannot do any activities

7. **Frequency of pain**

0	1	2	3	4
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

8. **Lifting**

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. **Walking**

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. **Standing**

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Patient Signature _____ Date _____

KEEHN CHIROPRACTIC OFFICE SC
FINANCIAL POLICY AND AUTHORIZATION

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE
We offer a same day discount off your visit if you make payment at the time services are rendered. You may set up a payment plan for the first visit; however, future services need to be paid in full at the time of service.

GROUP OR INDIVIDUAL INSURANCE
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

"ON THE JOB" INJURY (Worker's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer denies the worker's compensation claim, you will become responsible for the balance. If you have health insurance, we can file to them per your request.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are three options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed. After the 6 months, we will set up a payment plan with you. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

FLEXPLANS/MEDICAL SAVINGS ACCOUNTS
Please inform us if you have a medical savings account, sometimes known as a 'flex plan.' We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT
If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, a check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

INTEREST CHARGED ON PAST-DUE ACCOUNTS
Past due accounts (greater than 90 days) will be assessed a monthly interest charge of 1.5% on the patient balance due.

MISSED APPOINTMENTS
In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

If you miss two appointments without calling to cancel, thereafter, you will be charged for each missed appointment that you do not call and cancel prior to the appointment.

Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

I have read and understand the payment policy of Keehn Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Keehn Chiropractic and my insurance company. I request that Keehn Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 120 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Keehn Chiropractic that fees will be due and payable immediately.

_____ _____

Patient's signature (or guardian if patient is a minor) **Date**

_____

Staff Signature

DOCTOR PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VCS complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VCS, they are not internal medical specialist. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care, if he/she is aware that such care may be contraindicated. Again, it is the

responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS and VSC. Since there are so many variables it is difficult to predict the time schedule or efficacy of cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

PLEASE discuss any question or problems with the doctor before signing this statement of policy.

I HAVE READ AND UNDERSTAND THE FORGOING.

_____ _____

SIGNATURE **DATE**

Effective Date: September 23,2013

Keehn Chiropractic

Your Key to better health!

HIPAA Notice of Privacy Practices

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 Leann Peart.

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding Health Information about you
- Follow the term of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information.") Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer, Leann Peart.

For Treatment. We may use and disclose Health Information for your treatment and to provoke you with treatment-related health care services. For example, we may disclose your Health Information to doctors, technicians, or other personnel, including people outside our office, who are in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. Theses uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the chiropractic care you receive is of the highest quality. We may also share information with other entities that have a relationship with you (for example, you health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or healthrelated benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may release Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medication or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Health Information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to indentify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disaster whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHERS USES AND DISCLOSURES

The following are uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of your Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Leann Peart. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record) you have the right to request that an electronic copy of your record be give to you to or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format of if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have a right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Leann Peart.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Leann Peart.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make you request, in writing, to Leann Peart. We are not required to agree to your request unless you are asking us to restrict the use and disclosures of you Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at certain locations. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Leann Peart. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper CopY of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, http://www.keehnchiro.com. To obtain a paper copy of this notice, make a written request to Leann Peart.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

COMPLAINTS:

IF you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Leann Peart. All complaints must be made in writing. You will not be penalized for filing a complaint.

Printed name: _____

Signature: _____ Date: _____