LAKE MARY CHIROPRACTIC CENTER　　PATIENT INTAKE

Date:____________

FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE. WE ARE REQUIRED TO MAINTAIN ORIGINAL X-RAYS AND RECORDS AS PROPERTY OF THIS CLINIC. X-RAY COPIES ARE AVAILABLE ON CD FOR $10.

PERSONAL INFORMATION

Full Name ______________________________ SS# ______________

Address ______________________ City ____________ State ____ Zip ________

Home Phone ____________ Work Phone ____________ ext.______ Cell Phone ____________

Sex ☐ M ☐ F　Marital Status ☐ S ☐ M ☐ D ☐ W　Age _____　Birthday ___/___/___　Email ______________

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ________ How did you hear about our clinic? ____________

Emergency Contact Name ______________________ Phone ____________

INSURANCE INFORMATION

PLEASE COMPLETE THE ACCIDENT INJURY REPORT IF YOUR SYMPTOMS ARE A RESULT OF AN ACCIDENT

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If insured is self, complete any information not listed above. If insured is someone other than yourself, please complete all information below.

Insured's Full Name ______________________________ Insured's Date of Birth ___/___/___

Address ______________________ City ____________ State ____ Zip ________

Home Phone ____________________ Work Phone ____________ ext. ______

Insurance Company ______________________ Phone ____________

Group # ____________________ Insured's ID # ____________________

Employed by ______________________ Phone ____________

Additional Insurance Company ______________________ Phone ____________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Full Name ______________________________ Insured's Date of Birth ____/____/____

I understand that my insurance company states that this information is not a guarantee for payment and that my benefits could change or be denied. I also understand that my insurance company can take at least 60 days to respond to submitted claims and that it is my responsibility to inform this clinic of any changes in my policy. I agree to pay, in a current manner, any balance of said professional service charges over and above my insurance company's payments.

I hereby instruct and direct payment to be made by my insurance carrier to:

Lake Mary Chiropractic Center
3240 W. Lake Mary Blvd., Ste. 1300
Lake Mary, FL 32746

A photocopy of this authorization shall be considered as effective and valid as the original. I authorize the use of this form for all insurance claims from Lake Mary Chiropractic Center.

Patient Name ____________________ Patient's Signature ____________________ Date ________

Lake Mary
Chiropractic
Center ®

3240 W. Lake Mary Blvd, Suite 1300
Lake Mary, FL 32746
Office: (407) 302-5161 • Fax: (407) 302-5175
www.LakeMaryChiropractic.com

PATIENT HEALTH ASSESSMENT

NAME ______________________ CASE # ____________ DATE ____/____/____

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol to mark all affected areas.

R L L R

NUMBNESS	BURNING	STABBING	PINS & NEEDLES
" " "	X X X	/ / /	0 0 0

Type of care patient Interested In: ☐ Temporary Relief ☐ Lasting Correction

Major Complaints

____

____

____

____

____

____

____

____

____

2. How would you describe pain?
   - ☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
   - ☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

3. How would you rate the intensity of your pain? *(Circle the appropriate number)*

   0 1 2 3 4 5 6 7 8 9 10

   (no pain) *(terrible/unbearable pain)*

4. How often is the pain present?
   ☐ Constant (80-100%) ☐ Frequent (50-80%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

How did this condition develop? ______________________________

____

Any accidents, falls, etc. that might have caused your problem? ______________________________

When was the very first time you experienced these symptoms? ______________________________

Have you previously experienced this type of condition? ______________________________

Has this problem been getting better, worse or staying the same? ______________________________

Is there anything you do that makes your condition worse? ______________________________

How is this condition affecting your:

a. Home life ______________________________

b. Occupational life ______________________________ Your Occupation ______________

c. Recreational activities ______________________________

d. Rest and sleep ______________________________

Have you ever been in an automobile accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Have you seen another doctor for this problem? ☐ Y ☐ N Name ______________________________

Are you currently taking any medication? (prescriptions & OTC) ☐ Y ☐ N Specify ______________________________

Any chiropractor consulted in the past? ☐ Y ☐ N Name ______________________________

Date consulted ____/____/____ For what problem ______________________________

Current or Previous Symptoms

Doctor or staff obtaining patient history should indicate current symptoms with "C" and previous symptoms with "P"

- ❑ Headache
- ❑ Head seems too heavy
- ❑ Loss of memory
- ❑ Equilibrium problems
- ❑ Dizziness
- ❑ Fainting
- ❑ Tremors
- ❑ Palpitation
- ❑ Neck pain/stiffness
- ❑ Neck motion restricted
- ❑ Upper back pain/stiffness
- ❑ Low back pain/stiffness
- ❑ Pins and needles in arms/legs
- ❑ Numbness in fingers, arms, legs
- ❑ Chest pain
- ❑ Eye strain
- ❑ Pain behind eyes
- ❑ Eyes sensitive to light
- ❑ Ears buzzing/ringing
- ❑ Loss of taste/smell
- ❑ Sinus trouble
- ❑ Extreme nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Anxiety/depression
- ❑ Insomnia
- ❑ Excess perspiration
- ❑ Digestive disorders
- ❑ Nausea, vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Difficulty in excessive lifting
  - ❑ Light
  - ❑ Moderate
  - ❑ Repetitive
- ❑ Difficulty in excessive
  - ❑ Standing
  - ❑ Walking
  - ❑ Sitting
  - ❑ Bending
- ❑ Extreme fatigue
- ❑ Shortness of breath
- ❑ Pain radiating into
  - ❑ Right arm
  - ❑ Left arm
  - ❑ Both arms
  - ❑ Right leg
  - ❑ Left leg
  - ❑ Both legs
  - ❑ Neck
  - ❑ Base of skull
  - ❑ Shoulders
  - ❑ Hips

Social History

Height ________ Weight now ____________ One year ago ____________ Change in last two years ____________

Weight maximum ____________ Age ________ Adult minimum ____________ Age ____________

Are you dieting? ❑ Y ❑ N How? ____________

Are you a vegetarian? ❑ Y ❑ N If No, how often do you eat red meat? ____________

Approximate number of times you urinate during the day? ____________ Night? ____________

How often do you have a bowel movement? ____________

Do you drink caffeinated beverages? ❑ Y ❑ N What kind? ____________ Cups/day ____________

Do you smoke? ❑ Y ❑ N How many per day? ____________ Since when? ____________

Do you use other tobacco products? ❑ Y ❑ N What? ____________

Average number of alcoholic drinks/week? ________ What is your uncorrected vision? right ________ /20, left ________ /20

Has your vision changed lately? ❑ Y ❑ N How? ____________

How is your sleep? ____________ Average # of hrs/night? ____________

Do you wear heel lifts or other foot supports? ❑ Y ❑ N Explain ____________

Women Only: Menstrual History

Date of onset of last period ____/____/____ Age at onset ________ Are your periods regular? ❑ Y ❑ N

If not explain ____________

Do you experience cramping? ____________ Do you have any pre-menstrual symptoms? ____________

If so, what? ____________

Are you currently pregnant? ❑ Y ❑ N Are you currently using birth control? ❑ Y ❑ N What? ____________

Family Health History

	SELF	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN	
	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )	Age( )
Arthritis										
Asthma										
Back Pain										
Bursitis										
Cancer										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Migraines										
Nervousness										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other										

TERMS OF ACCEPTANCE, POLICIES, AND CONSENT FOR CARE

1. All first visit charges are payable when services are rendered.

2. I authorize the taking of photographs and x-rays and performance of other diagnostic and therapeutic procedures to be used for treatment purposes.

3. I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. .I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone by doctors of chiropractic.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, ____________________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

____ ____________________
(Signature) (Date)

Complete if Patient is a minor child.

____
(Print Child's Name)

I, ____________________________________ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ ____________________
(Signature) (Date)

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

______________________	______________________
Patient Name (printed)	Relationship to patient
______________________	______________________
Patient or legal Guardian Signature	Date
______________________	______________________
Witness Signature (office staff)	Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

______________________________ __________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

PATIENT'S REQUEST FOR COPIES OF RECORDS

I hereby request a copy of my patient records and x-rays from ______________________(name of practice). I request the copies: (check one) on paper ____ in electronic format _____ by email transmission to (fill in email address) ______________________________________. I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

____ __________________________________

Patient's or Patient's Legal Representative's Signature Date Signed

YOU MAY REFUSE TO SIGN THIS REQUEST.

DOCUMENTS FURNISHED TO PATIENT:

X-RAYS FURNISHED TO PATIENT:

DATE RECORDS OR X-RAYS FURNISHED TO PATIENT:

Lake Mary Chiropractic Center ◦ 3240 W. Lake Mary Blvd. Suite 1300 ◦ Lake Mary, FL 32746 ◦ 407-302-5161

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize Lake Mary Chiropractic Center to release a copy of my patient records or x-rays containing protected health information to. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

____ __________________
Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

________________________________ Date Signed

Specific description of information to be disclosed:

Lake Mary Chiropractic Center ∘ 3240 W. Lake Mary Blvd. Suite 1300 ∘ Lake Mary, FL 32746 ∘ 407-302-5161

PAIN DISABILITY QUESTIONNAIRE

Patient Name ____ Date __________________________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and circle the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

Lake Mary Chiropractic Center ®

3240 W. Lake Mary Blvd Ste 1300
Lake Mary, FL 32746
Office: (407) 302-5161 • Fax: (407) 302-5175
www.LakeMaryChiropractic.com

MEDICAL RECORDS / X-RAY RELEASE FORM

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: ________________ **Account #:** ________________

Persons Authorized to Use of Disclose Information
Information listed above will be used or disclosed by:______________________

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to Lake Mary Chiropractic Center

Name: __________________ **Social Security #:** _____________
Date of Birth: _____________

I hereby request and authorize that the following medical documents/records to be released and that they be promptly transferred to Lake Mary Chiropractic Center.

_____ X-Ray Report
_____ Complete Medical File
_____ Medical Reports
_____ Daily Notes
_____ Other _________________

Purpose of Disclosure
_____ Continuing care with another physician or hospital
_____ Personal Copy
_____ Other (please specify) ____

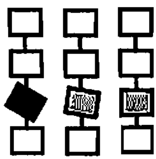
Expiration Date of Authorization
This authorization is effective through __/__/__ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Lake Mary Chiropractic Center. You should contact the Compliance Office to terminate the authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

____
Patient Signature Date

____
Witness Signature Date



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Appointment Cancellation Policy

Dear Patient:

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient who needs care.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the doctor, massage therapist, and/or personal trainer. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment ("No-Show, No-Call."). **We reserve the right to charge a fee of $30.00 to any patient for either a missed appointment or an appointment cancelled without 24 hours notice.** If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment will be cancelled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, ____ (print name), have received a copy of Lake Mary Chiropractic Center's Appointment Cancellation Policy.

______________________________ ______________________________
Printed Name of the Patient | Relationship to Patient (if patient is a minor)

______________________________ ______________________________
Signature of Patient or Responsible Party if a Minor | Date

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Lake Mary Chiropractic Center
EFFECTIVE DATE OF THIS NOTICE: APRIL 14TH, 2003

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you, your treatment, and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Kelly Toma at 407-804-8778.

C. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:

1. Treatment: The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. Many of the people who work for our practice may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment: Our practice may use and disclose your PHI in order to bill you for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members.

3. Health Care Operations: Our practice may use and disclose your PHI to operate our business. As an example, our practice may use your PHI to evaluate the quality of care you received from us. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointments and Reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment or a follow up on treatment.

5. Non-Medical Communications: Our practice may use your PHI to contact you for non-medical reasons, such as sending you a birthday card or a holiday greeting.

6. Treatment Options: Our practice may use your PHI to inform you of potential treatment options or alternatives. We may treat you in an open treatment area and some incidental PHI may be overheard by other patients being treated at the same time.

7. Health-Related Benefits and Services: Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. For example; we may send you newsletters that may include information about our practice, health related issues and products and services.

8. Release of Information to Family/Friends: Our practice may release your PHI to a family member or friend that is involved in your care, or who assists in taking care of you. For example, a parent/guardian may ask that a babysitter take their child to the pediatrician's office for treatment. In this example, the babysitter may have access to this child's medical information.

9. Disclosures Required By Law: Our practice will use and disclose your PHI when we are required to do so by law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

1. Public Health Risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

A. Maintaining vital records, such as births and deaths;
B. Reporting child abuse or neglect;
C. Preventing or controlling disease, injury or disability;
D. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
E. Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; and
F. Reporting problems with products or devices;
G. Notifying individuals if a product or device they may be using has been recalled

2. Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process

by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

A. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
B. Concerning a death we believe has resulted from criminal conduct;
C. Regarding criminal conduct at our offices;
D. In response to a warrant, summons, court order, subpoena or similar legal process;
E. To identify/locate a suspect, material witness, fugitive or missing person; and
F. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased Patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

6. Organ and Tissue Donation: Our practice may release your PHI to organizations that handle organ or tissue transplantations as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research: Our practice may use and disclose your PHI for research purposes in certain circumstances (i.e. case studies). We will obtain your written authorization to use your PHI for research purposes <u>except when</u> an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research; and (C) adequate written assurances that the PHI will not be disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without the use of the PHI.

8. Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety, the health and safety of another individual, and/or the public. Under these circumstances, we will only make disclosures to a person/organization able to help prevent the threat.

9. Military: Our practice may disclose your PHI if you are a member of U.S./foreign military force and if required by the appropriate authorities.

10. National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may disclose your PHI to federal officials in order to protect the President, other officials, or to conduct investigations.

11. Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI:

1. Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Kelly Toma** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use of your PHI, you must make your request in writing to **Kelly Toma.** Your request must describe in a clear and concise fashion:

A. The information you wish restricted;
B. Whether you are requesting to limit our practice's use, disclosure or both; and
C. To whom you want the limits to apply.

3. Inspection and Copies: You have the right to obtain a copy of the PHI, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Kelly Toma** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. Your request must be made in writing and submitted to **Kelly Toma.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request, and the reason supporting your request, in writing. Also, we may deny your request if you ask us to amend information that is in our opinion.

5. Accounting of Disclosures: All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Kelly Toma.**

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice: You are entitled to receive a paper copy of our notice of privacy practices.

7. Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time <u>in writing</u>. Please note, we are required to retain records of your care.

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Lake Mary Chiropractic Center
EFFECTIVE DATE OF THIS NOTICE: APRIL 14TH, 2003

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you, your treatment, and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Kelly Toma at 407-804-8778.

C. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:

1. Treatment: The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. Many of the people who work for our practice may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment: Our practice may use and disclose your PHI in order to bill you for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members.

3. Health Care Operations: Our practice may use and disclose your PHI to operate our business. As an example, our practice may use your PHI to evaluate the quality of care you received from us. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointments and Reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment or a follow up on treatment.

5. Non-Medical Communications: Our practice may use your PHI to contact you for non-medical reasons, such as sending you a birthday card or a holiday greeting.

6. Treatment Options: Our practice may use your PHI to inform you of potential treatment options or alternatives. We may treat you in an open treatment area and some incidental PHI may be overheard by other patients being treated at the same time.

7. Health-Related Benefits and Services: Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. For example; we may send you newsletters that may include information about our practice, health related issues and products and services.

8. Release of Information to Family/Friends: Our practice may release your PHI to a family member or friend that is involved in your care, or who assists in taking care of you. For example, a parent/guardian may ask that a babysitter take their child to the pediatrician's office for treatment. In this example, the babysitter may have access to this child's medical information.

9. Disclosures Required By Law: Our practice will use and disclose your PHI when we are required to do so by law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

1. Public Health Risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

A. Maintaining vital records, such as births and deaths;
B. Reporting child abuse or neglect;
C. Preventing or controlling disease, injury or disability;
D. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
E. Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; and
F. Reporting problems with products or devices;
G. Notifying individuals if a product or device they may be using has been recalled

2. Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process

by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

A. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
B. Concerning a death we believe has resulted from criminal conduct;
C. Regarding criminal conduct at our offices;
D. In response to a warrant, summons, court order, subpoena or similar legal process;
E. To identify/locate a suspect, material witness, fugitive or missing person; and
F. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

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