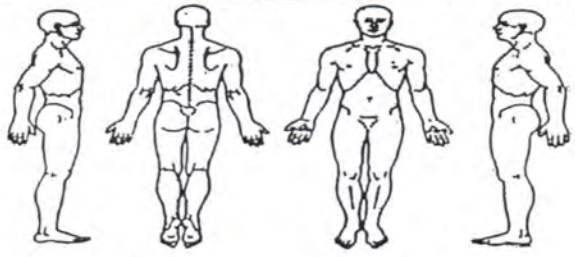
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms (color in, shade, circle,etc)



3. How often do you experience your symptoms?
   - □ Constantly (76-100% of the time)
   - □ Frequently (51-75% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - □ Sharp
   - □ Dull
   - □ Diffuse
   - □ Achy
   - □ Burning
   - □ Shooting
   - □ Stiff
   - □ Numb
   - □ Tingly
   - □ Sharp with motion
   - □ Shooting with motion
   - □ Stabbing with motion
   - □ Electric like with motion
   - □ Other:_____

5. How are your symptoms changing with time?
   □ Getting Worse □ Staying the Same □ Getting Better

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

7. How much has the problem interfered with your work?
   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
   □ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?
   - □ Chiropractor
   - □ ER physician
   - □ Massage Therapist
   - □ Neurologist
   - □ Orthopedist
   - □ Physical Therapist
   - □ Primary Care Physician
   - □ Other:_____
   - □ No one

9a. Have you had imaging performed (Xray/CT/MRI, etc) if so where?

_____

10. How long have you had this problem? _____ Have you had the problem before?_____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
   □ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

13a. What alleviates your problem (what makes it feel better)?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____
   Occupation _____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus/multiple sclerosis
□ Heart Problems □ Cancer □ ALS

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

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders		□	Depression
□	□	Wrist Pain	□	□	Bladder Infection		□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination		□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite			For Females Only
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis		□	Dizziness			
□	□	Other:_____						

20. List all prescription or over the counter medications you are currently taking:
_____

20a. List any vitamins or supplements you are currently taking:
_____

21. Please indicate who your Primary Care Doctor and his/her location (if known):
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
If yes, why _____

26. Have you had significant past trauma? □ No □
Yes,explain_____

26a. Have you seen a chiropractor before?_____ If so was if for a similar condition?_____

27. Anything else you want the Dr. to know about your visit today?_____

Patient Signature_____ Date:_____

NECK DISABILITY INDEX

Name:_____ Date:_____ File #:_____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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.
- ☐ 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 with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ 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 due to pain.

SECTION 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

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 not do any work at all.

SECTION 8 – Driving
- ☐ I can 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 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 mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 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 neck pain.
- ☐ 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.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

REVISED OSWESTRY INDEX

Name:_____ Date:_____ File #:_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

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.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. 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 only lift very light weights at the most.

SECTION 4 – Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- ☐ My social life is normal and gives me no 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 much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 – Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 – Changing Degrees 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 slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

Patient Information

Last Name_____First Name_____ Middle Initial___
Gender M/F Date of Birth___/___/____ Age____
Email Address_____SS#_____
Home Address_____
City_____State_____ ZipCode_____
Home Phone#( )_____ Cell#( )_____ Work# ( )_____
Are you currently employed? Y / N if no, are you retired? Y/ N
Employer Name_____ Occupation_____
Employer Address_____
Employer City_____State_____ ZipCode_____
Primary Doctor's Name_____City_____State____

Spouse/Partner Last Name_____First_____Middle___
Spouse Date of Birth__/__/___ Employer Name_____
Employer Address_____
Spouse Employer Phone#_____Spouse Cell#_____
In case of Emergency who should we contact?_____Phone#_____

Are you financially responsible for this account? Y / N if not, who is?_____
Insurance Co. address_____City_____State____Zip_____
Insurance Co. Phone#( )_____Group#_____
Do you have a Deductible? Y/ N if yes, how much is it_____
Do you have additional insurance? Y/N if yes, complete following questions

Additional Insurance Co. Name_____
Additional Insurance Address_____City_____State____
ZipCode_____Group#_____Phone#( )_____

I certify that all the above information is correct and I request services.
X_____Date_____
Signature of patient/guardian or person acting on patient's behalf

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I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand the information can and will be used to conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.
X_____Date_____
Signature of patient/guardian or person acting on patient's behalf

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Assignment of Benefits and authorization to proceed with care-I understand and agree that my health insurance policy is an arrangement between myself and my carrier. Furthermore, I understand that Delmar Chiropractic Office (D.C.O) will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount that is authorized to be paid to the provider will be credited to my account. However, I also understand and agree that all services rendered are charged directly to me and that I am ultimately responsible for payment. I hereby assign all my rights under my health insurance policy to D.C.O with respect to any claims for reimbursement for health services rendered. I also authorize the release of any medical information to interested 3rd parties as well as other health care professionals. Finally, I understand that if I am accepted as a patient, I am authorizing the treating chiropractor to proceed with any necessary treatment. Any risks regarding Chiropractic care will be explained upon request. X_____Date_____
Signature of patient/guardian or person acting on patient's behalf

PATIENT ACKNOWLEDGEMENT FOR RESPONSIBILITY OF MAINTENANCE AND NON-COVERED BENEFITS

Under your current health insurance, you may be financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered benefits as well as care determined to be maintenance. Financial responsibility is expected to be fulfilled at the time services are rendered.

Non-covered benefits: Your plan may exclude payment for certain devices, supplies or services. These items typically include but are not limited to supportive braces, vitamins, orthotics, traction units and rehabilitative equipment.

Maintenance Care: Your plan does not provide coverage for maintenance care. This care is defined as care that is supportive/elective in nature by your insurance company and is not covered by your plan. Based upon contractual agreement between Delmar Chiropractic Office and your insurance company, we can not bill your insurance for this type of care. However, regular chiropractic check-ups have been shown to help improve the overall functioning of your spine as well as manage chronic conditions and prevent future relapses.

I _____, acknowledge that I have been told in advance by Delmar
PATIENT NAME
Chiropractic Office that the services listed above are not covered by my insurance plan.

And that I am ultimately responsible for payment of these services.

Patient Signature_____ Date_____
PARENT/LEGAL GUARDIAN

Patient Name_____
PRINTED

Witness_____
Staff Member

** If during the course of Maintenance Care, you develop a new problem or your original condition worsens, care may no longer be considered Maintenance and you may then be covered by your health plan again. **

If you should have any questions regarding the particulars of your individual insurance plan, please feel free to contact Debbie and she will do her best to rectify any challenges you may have.

We look forward to the opportunity of serving you and your family in your quest for better spinal health.

PRIVACY
Notice to Patients

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- **Care** – In order to provide care to you, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your medical condition and needs and provide advice or treatment (e.g., your physician). For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.
- **Payment** – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services that you received from the Practice so that the Practice can be properly reimbursed.
- **Health Care Operations** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

1. **De-identified Information** – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.
2. **Business Associate** – To a business associate, which is someone who the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.
3. **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
4. **Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.
5. **Federal Drug Administration** – If required by the Food and Drug Administration to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.
6. **Abuse, Neglect or Domestic Violence** – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm or if the Practice believes that you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
7. **Health Oversight Activities** – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.
8. **Judicial and Administrative Proceeding** – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
9. **Law Enforcement Purposes** – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.
10. **Coroner or Medical Examiner** – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.
11. **Organ, Eye or Tissue Donation** – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
12. **Research** – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board and the requirement that protocols must be followed.
13. **Avert a Threat to Health or Safety** – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

14. **Specialized Government Functions** – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

15. **Inmates** – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.

16. **Workers' Compensation** – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

17. **Disaster Relief Efforts** – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

18. **Required by Law** – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization, which you may revoke at any time.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available the Practice will leave a message for you.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives, or other health benefits or service that may be of interest to you.

YOUR RIGHTS

You have the right to:

- Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

- Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason and support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

- Receive an accounting of disclosures of your PHI as provide by law. To request an accounting, you must submit a writte request to the Practice's Privacy Officer. The request mus state a time period which may not be longer than six year and may not include the dates before April 14, 2003. Th request should indicate in what form you want the list (suc as a paper or electronic copy). The first list you request withi a 12 month period will be free, but the Practice may charg you for the cost of providing additional lists in that same 1 month period. The Practice will notify you of the costs involve and you can decide to withdraw or modify your request befor any costs are incurred.

- Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

- Complain to the Practice, or to the Secretary of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue, S. W., Room 509F HHH Building, Washington, D.C. 20201. Or you may contact a regional office of the Office of Civil Rights, which can be found at www.hhs.gov/ocr/regmail.html. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

- To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer.

PRACTICE'S REQUIREMENTS

The health care office:

- Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of the Practice's legal duties and privacy practices with respect to your PHI.

- Is required to abide by the terms of this Privacy Notice.

- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

- Will not retaliate against you for making a complaint.

- Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.

- Will post this Privacy Notice on the Practice's web site, if the Practice maintains a web site.

- Will provide this Privacy Notice to you free of charge upon request.

Delmar Chiropractic
Office
204 Delaware Avenue
Delmar, New York 12054