All Spine Chiropractic and Wellness, LLC

PATIENT INFORMATION

Name: _____ Date: _____

Address_____City_____ State_____ Zip Code _____

Phone: (H) _____ (W) _____ (C) _____

Email Address _____

☐ I authorize All Spine Chiropractic and Wellness, LLC to send me emails reminders & newsletters.

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Social Security #_____

Occupation_____Employer_____

Emergency Contact Name_____Emergency Contact's Number_____

☐ I authorize All Spine Chiropractic and Wellness, LLC to leave or give information to my emergency contact.

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor/Office: _____

CHIEF COMPLAINT (CC)

1. **Primary reason:**

_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____

_____

2. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   - A. Loss of Range of Motion: yes/no
     - a. What body parts: _____
   - B. Visual Disturbance : yes/no ☐ blurring l/r ☐ floaters l/r ☐ vision loss l/r ☐ hypersensitivity l/r
     % of time: ___ % of time: ___ % of time: ___ % of time: ___
   - C. Dizziness: yes/no % of time: ____
   - D. Anxiety: yes/no % of time: ____
   - E. Depression: yes/no % of time: ____
   - F. Difficulty Sleeping: yes/no % of time: ____

PAST FAMILY SOCIAL HISTORY (PFSH)

A. Please indicate if you have a history of any of the following:

☐ Anticoagulant use ☐ Heart problems/high blood pressure/chest pain ☐ Bleeding problems
☐ Lung problems/shortness of breath ☐ Cancer ☐ Diabetes ☐ Psychiatric disorders
☐ Bipolar disorder ☐ Major depression ☐ Schizophrenia ☐ Stroke/TIA's ☐ Other _____
☐ None of the above

All Spine Chiropractic and Wellness, LLC
5931 Nieman Rd, Ste 100
Shawnee, KS 66203
Phone (913) 914-7090 Fax (913) 391-6565

Name: _____ Date: _____

B. Previous Injury or Trauma:

_____

_____

C. Have you ever broken any bones? Which?

_____

_____

D. Allergies:

_____

_____

E. **Medications:**

Medication Reason for taking

_____

_____

_____

F. Surgeries:

Date Type of Surgery

_____

_____

_____

Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

_____

_____

_____

G. Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases

□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes

□ Other _____ □ None of the above

Deaths in immediate family:

_____

Cause of parents or siblings death Age at death

_____

_____

_____

3. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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MECHANISM OF INJURY

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

1) In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

2) Were you surprised by the impact? **Yes** / **No**

If "NO", how did you brace? **With Hands** / **With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

3b) Were you leaning forward at the time of impact? **Yes** / **No**

4) What type and year of vehicle were you in? _____

_____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph.

5) What type and year of vehicle struck yours?_____

_____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph.

6) Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

7) Did you feel pain immediately after the accident? **Yes** / **No**

Were you rendered unconscious as a result of the accident? **Yes / No**

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Name: _____ Date: _____

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes** / **No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: _____

Police and Ambulance:

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches /**
Muscle Relaxants / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Patient Signature Date

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Name: _____ Date: _____

REVIEW OF SYSTEMS (ROS)

For new patients, established patients who may be having a new problem, or our patients who we have not seen in a while, we need to update our records as to your general health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

Constitutional Symptoms (Health in General) □ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other:_____

Eyes □ No Problems Blurred vision, crossed eyes, eye pain, discharge
Other:_____

Ears, Nose, Mouth & Throat □ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other:_____

Cardiovascular (Heart Related) □ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:_____

Respiratory (Lungs & Breathing) □ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other:_____

Gastrointestinal (Stomach & Intestines) □ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other:_____

Genitourinary (Reproductive Organs & Urinary) □ No Problems Hematuria, excessive/reduced urination, kidney/bladder infections. Other:_____

Musculoskeletal (Muscles, Bones & Joints) □ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other:_____

Integumentary (Skin, Hair & Breast) □ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:_____

Neurologic (Brain & Nerves) □ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other:_____

Psychiatric (Mood & Thinking) □ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other:_____

Endocrine (Glands) □ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:_____

Hematologic/Lymphatic (Blood/Lymph) □ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other:_____

Allergic/Immunologic □ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other:_____

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient or Guardian Signature _____ Date_____

FOR OFFICE USE ONLY:
Practitioner: _____
Reviewed Date: _____

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Name: _____ Date: _____

HISTORY OF PRESENT ILLNESS (HPI)

Symptom 1 (Chief Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

Symptom 2 (Secondary Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

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Name: _____ Date: _____

Symptom 3 (Additional Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

Symptom 4 (Additional Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

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Name: _____ Date: _____

Symptom 5 (Additional Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

Symptom 6 (Additional Complaint): _____

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:_____
- Severity: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? _____
- Context: How did the symptom begin? _____
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)_____
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: Does the symptom radiate to another part of your body (circle one):
  Yes No If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day Constant

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Name: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC SPINAL MANIPULATION, DIAGNOSITC X-RAYS AND TREATMENT, AUTHORIZATION AND RELEASE

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, dry needling, traction, spinal decompression, Graston soft tissue, Kinesio/Rock Tape, therapeutic exercises) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of the All Spine Chiropractic and Wellness, LLC, or any doctor, who now or in the future, works as a relief doctor.

Initials:_____ **Physician's Signature:_____**

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic manipulation and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternative to care might include self-administered over the counter analgesics and rest, medical treatment; prescription drugs, such as anti-inflammatory, muscle relaxants and pain-killers, surgery or doing nothing. I understand the risks and dangers attendant to remaining untreated; over time this may complicate treatment making it more difficult and less effective the longer treatment is postponed. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest. **Initials:_____** **Physician's Signature:_____**

I authorize payment of insurance benefits directly to the All Spine Chiropractic and Wellness, LLC. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the Smith Chiropractic Inc. to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.
Initials:_____

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature:_____Date____/_____/_____

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Name: _____ Date: _____

Printed Name:_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES PURSUANT TO HIPAA AND CONSENT FOR USE OF HEALTH INFORMATION

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____ **on**_____
Patient Signature Today's Date

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (Circle One)

FOR FEMALES ONLY

To the best of your knowledge, are you pregnant (or do you think you could be)?

Yes _____ No _____ Possibly _____

Patient Signature:_____Date_____

CONSENT TO TREATMENT OF A MINOR

I hereby authorize the doctors of All Spine Chiropractic and Wellness, and/or whomever they designate as assistants, to administer treatment as deemed necessary to_____.

Signature of Parent or Legal Guardian:_____Date_____

Relationship:_____

Witness signature:_____Date_____

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Name: _____ Date: _____

All Spine Chiropractic and Wellness, LLC

Notice of Patient Privacy Policy

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 our Privacy Officer or any staff member in our office.

Our Privacy Officer is Dr. Alissa Gould, DC

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.allspinechiro.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice. Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between

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Name: _____ Date: _____

you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- disclosures of psychotherapy notes
- uses and disclosures of Protected Health Information for marketing purposes;
- disclosures that constitute a sale of Protected Health Information;
- Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

 Others Involved in Your Healthcare: 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

 Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

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☐ **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

☐ **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

☐ **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

☐ **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

☐ **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

☐ **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

☐ **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

☐ **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

☐ **You have the right to inspect and copy your protected health information.**

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

☐ **You have the right to request a restriction of your protected health information.**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. You may opt out of

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fundraising communications in which our office participates.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt

□ You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

□ You may have the right to have your doctor amend your protected health information.

This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record. □ You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

□ You have the right to be notified by our office of any breech of privacy of your Protected Health Information. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us.

To file a complaint, you may go to: http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Dr. Alissa Gould, DC you may contact our Privacy Officer, or any staff member, at the following phone number 913-914-7090 or our website, at www.allspinechiro.com for further information about the complaint process. This notice was published and becomes effective on December 29, 2022.

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YOU HAVE THE RIGHT TO RECEIVE A "GOOD FAITH ESTIMATE" EXPLAINING HOW MUCH YOUR MEDICAL CARE WILL COST

Under the law, health care providers need to give patients who do not have insurance, or who are not using insurance, an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

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