ATLAS PAIN INSTITUTE

(512) 332-2777 • 1001 Chestnut Suite C Bastrop, TX 78602 • www.atlaspaininstitue.com

Patient Registration Information

Date: ______________

How did you decide to come to our office? ☐Newspaper ☐ Yellow Pages ☐ Website ☐ Referred By:______________________

Is your visit due to an accident? ☐ Yes ☐ No Age: ______ Date of Birth: __________ Gender: _________

Name:________________________Address: ____________________________City: _______________ State: ___Zip Code:______

Home Ph#: ____________________ Cell Ph#: ________________________ Email: ________________________________

SSN: ______________________________ D.L. #____________________

Employer: ____ Work Ph: ____________________________

Spouse:______________________ Ph #__________________ Employer____________________ Ph# ____________________

Name of nearest relative (other than spouse) :____Ph# ______________________

In case of emergency contact: ____ Ph# _____________________

PRESENT COMPLAINT:

Describe Your Pain (circle) *no pain* **Grade Pain Level** (circle) *extreme pain*

Headache	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes
Neck Pain	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes
Mid-back pain	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes
Low back pain	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes
Shoulder pain R / L	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes
Arm/Wrist/Hand pain R / L	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes
Hip Pain R / L	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes
Leg/Ankle/Foot R / L	sharp	dull	ache	radiating	numbness	0 1 2 3 4 5 6 7 8 9 10	Constant comes & goes

Other: ____ 0 1 2 3 4 5 6 7 8 9 10 Constant comes & goes

When did the pain start? __________________________________

What makes the pain better? Sitting standing laying down walking nothing other:______________________

What makes the pain worse? Sitting standing laying down walking nothing other:______________________

What have you done for the pain? Pain killers Ice heat aspirin nothing other:__________________________

Other doctors seen for this problem: ____

Other treatment & results: ____

Hospitalized: ☐Yes ☐No How many days:________ # of days missed from work/school:_______

HEALTH HISTORY:

__polio	__diabetes	__rheumatism	__Scarlet Fever	__Digestive Disorders
__Anemia	__Hepatitis	__Concussion	__Heart Trouble	__High Blood Pressure
__Asthma	__Arthritis	__Convulsions	__German Measles	__Muscular Dystrophy
__Cancer	__Dizziness	__Nervousness	__Rheumatic Fever	__Other______________________
__Neuritis	__Numbness	__Tuberculosis	__Venereal Disease	
__Epilepsy	__Backaches	__Sinus Trouble	__Multiple Sclerosis	

Surgeries & Dates:____

____

Treated by a physician for any condition in the last 12 months? ☐ Yes ☐ No Describe: _________________________

Date of last physical exam: ______________Pregnant: ☐ Yes ☐ No Date of last menstrual period: ____________________

Patient Signature: ____ Date:__________________

Atlas Pain Institute, LLC
1001 Chestnut Street, Suite C
Bastrop, TX 78602

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:______________________ **Last Name:**______________________

Email address: ______________________@______________________

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

DOB: ___/___/_____ **Gender (Circle one):** Male / Female **Preferred Language:** ________________

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

Smoking Start Date (Optional): ________________

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (__________)	Offspring: (__________)
Example: Heart Disease		*X*		

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

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

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ________________________________ Date: ______________

For office use only

Height: ________ Weight: __________ Blood Pressure: _____/_____ Pulse__________

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Phone: (512) 332-2777
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atlaschiro1@hotmail.com

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. B Jason Trowbridge, D.C. (and whomever he/she may designate as his/her assistants) to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatments, the reasons why the above named treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. B. Jason Trowbridge, D.C.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I understand that the Brief Exam and Consultation of today's visit was at no charge to me; therefore any other test, x-rays taken and/or reports given are the sole property of this clinic and shall not be removed there from unless paid for in advance.

Patient or Legal Guardian Signature ______________________ Date ______________

Witness ______________________

Atlas Pain Institute, LLC

Health Insurance Election

(Accident and Non-Accident Cases)

How would you like for us to handle your health insurance? Please choose one:

☐ **Option 1 -- I Do Not Have Health Insurance / I Don't Want You to File My Health Insurance**

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may keep any health insurance, which I do have, on file as set forth in your Financial Policy. You may ask to be paid now or later as I am responsible for payment. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.

☐ **Option 2 -- I Want You to File My Health Insurance and Also to Help Me Verify My Benefits. To Help You Get Paid, I'll Make Partial Payments and/or Sign an Assignment & Financial Policy**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment even if this is an accident case. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now or later for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. If my condition is due to an accident case, I would ask that you delay from collecting such amounts as described in your Financial Policy. With this in mind, I agree to the terms of the Financial Policy. In the event that my health insurance delays or Denies Payment, I will be responsible for payment as described in the Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.

☐ **Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.

Important: I understand that in certain circumstances, the Office may have a policy of not filing health insurance or law may actually control or regulate the filing of insurance. This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Signature: ______________________________ Date: ___/___/___

Patient Name: ______________________________

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atlaschiro1@hotmail.com

PROVIDER/PATIENT ASSIGNMENT, LIEN, POWER OF ATTORNEY, RECORDS RELEASE, AND PAYMENT AGREEMENT

THIS AGREEMENT, entered into this date by and between ______________________________, Hereinafter called "Patient", and B. Jason Trowbridge, D.C., hereinafter called "Provider".

WHEREAS Patient desires to receive health care services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for the payment of such benefits, it is hereby agreed:

SECTION 1. Patient assigns to Provider any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of health care cost incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights relating to those benefits includes, but not limited to, the following describes policies plans:

____

____

____

This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by Patient for services rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of Patient's assignments of benefits is a convenience to patient, and that Provider may revoke this assignment at any time.

Section 2. Patient hereby grants Provider a lien against any proceeds resulting from any claim Patient has or may have against any party whose negligence may have caused Patient's injuries or illness. Patient also hereby grants a lien against the proceeds of any insurance policy or health care plan to which Patient is entitled as a result of services rendered to Patient by Provider. Said liens shall not exceed the total amount of expenses incurred by patient for services rendered by Provider.

Section 3. Patient hereby directs all insures and other persons responsible for Patient's health care cost to make all payments for healthcare services rendered by Provider directly to Provider.

Section 4. Patient hereby appoints Provider as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign, and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by Provider. Although Provider is granted such special powers contained herein, Provider is not obligated or compelled to exercise such powers but may do so at Provider's discretion. Patient agrees to cooperate with Provider in collecting such amounts.

Said cooperation shall include appearing in court if necessary. Patient further empowers Provider to request and receive from any insurer, employer, or other third party payer, any and all information and documentation pertaining to Patient's healthcare policies or plans, including a copy of such policies or plans, and any information or supporting documentation concerning or touching upon the handling, calculations, processing, or payment of any claims arising from services rendered to Patient by Provider.

Section 5. Patient agrees to waive any applicable statute of limitations which may at any time interfere with provider's rights to collect for services rendered to Patient.

Section 6. Patient agrees that in the event Patient receives any checks, drafts, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for Provider and will immediately deliver said check, draft, or payment to Provider. Provider agrees to apply the proceeds from said check, draft, or payments to Patient's debt for services rendered.

Section 7. Patient hereby authorizes Provider to release and permit the examination and/or copying of any Patient's medical records, x-rays, laboratory reports, and the results of all test of any type or character to such persons as Provider deems appropriate.

Section 8. Provider agrees to submit a copy of this agreement with the initial claim form(s) which Provider submits to third party(s) as notice to the third party payor (s) of the assignment and other agreements contained herein. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured, at any time or will, upon request by Patient/insured, be mailed to designated address.

Section 9. In the event that any section or provision of this agreement is legally void, invalid, or unenforceable, all other sections and provisions of this agreement shall remain in full force and effect.

Section 10. The assignments and agreements contained in this document may not by revoked by Patient without the express written consent of the Provider.

IN WITNESS WHEREOF, this agreement has been entered into the day and year set forth below.

______________________________ Patient Signature

______________________________ Date

______________________________ Witness

B. Jason Trowbridge, D.C. Provider

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED ____ X DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

ATLAS PAIN INSTITUTE, LLC
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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by ATLAS PAIN INSTITUTE, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. ______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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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. B. Jason Trowbridge,D.C.**

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. "**P**rotected **H**ealth **I**nformation" (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 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 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" 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.

- **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 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.

- **<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location.</u>** 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.

- **<u>You may have the right to have your doctor amend your protected health information.</u>** 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.

- **<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>** 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.

- ***<u>You have the right to be notified by our office of any breech of privacy of your Protected Health Information.</u>***

  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. B. Jason Trowbridge, D.C. You may contact our Privacy Officer, or any staff member, at the following phone number, (512) 332-2777 or email us at atlaschiro1@hotmail.com for further information about the complaint process.

This notice was revised, published and becomes effective on February 1, 2016.