**French City Chiropractic**
**228 Upper River Road**
**Gallipolis, OH 45631**
**740-446-3836**

Patient Name (Please Print): _____

# PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs as well as correcting all other associated musculoskeletal conditions that affect the quality of our lives. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Although we focus on corrective care programs, we realize that each patient's condition and circumstances are unique and we value and trust the patient's choice in the care he or she chooses to receive. We are committed and concerned about your health and would like to know what your expectations of care are.

**Please check the box that best describes what type of care you are looking for at this time.**

- ☐ I am only interested in a health consultation and to find out if chiropractic may be able to help, I do not want care for my condition at this time.
- ☐ I am only interested in symptomatic care and pain relief.
- ☐ I am interested in corrective care and finding a long term solution to my health problems.

Please fill out the following information accurately and completely so that the doctor can thoroughly evaluate your case. The doctor will use this information as well as your history, examination and x-rays (if required) to determine if you qualify for of our rehabilitative programs. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____
Patient Signature:

_____
Today's Date:

# CONFIDENTIAL PATIENT INFORMATION

Date: _____

## PATIENT APPLICATION SURVEY

Patient Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Employer Name: _____ Occupation: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

Names of Children: _____ Ages: _____

How were you referred to this office? _____

Do you have Health Insurance: □ Yes □ No Type of Insurance: □ Commercial/Private □ Medicare □ Medicaid

**Primary Insured / Party Responsible for Billing: (complete only if different)**

**(Please allow our staff to photocopy your driver's license and all insurance cards)**

Patient's Relationship to Primary Insured / Party Responsible for Billing: □ Self □ Spouse □ Child/dependent □ Other: _____

Insured's Name: _____

Insured's Birth Date: _____ / _____ / _____ Age: _____ Gender: M F Marital Status: S M D W

Insured's Social Security #: _____ - _____ - _____

Insured's Address: _____ Insured's Home Phone: ( ) _____

City, State, Zip: _____ Insured's Work Phone: ( ) _____

Email Address: _____ Insured's Cell Phone: ( ) _____

Employer Name: _____ Occupation: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

Primary Insurance Company: _____ Policy ID: _____ Group #: _____

Secondary Insurance Company: _____ Policy ID: _____ Group #: _____

AUTHORIZATIONS:

A. I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or not covered. I understand I am responsible for all copayments, deductibles and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

B. I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to an insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof.

C. I (we) hereby authorize and direct payment from third-parties for any medical/chiropractic benefits allowable to the doctor as payment toward the total charges for professional services rendered to be paid directly to this office/doctor. This payment will not exceed my indebtedness to the assignee.

D. I (we) authorize this office to maintain a photocopy of my driver's license and all available insurance cards. I agree that a photostatic copy of this agreement shall serve as the original.

My Preferred Payment Option(s) (please indicate): □ Cash □ Check □ Visa □ Mastercard □ AMEX

Patient Signature: _____ Date: _____

Parent/Guarding Signature: _____ Date: _____

Parent/Guarding Name: _____

# CONFIDENTIAL PATIENT INFORMATION

(please print)

Patient Name: _____ Date: _____

## PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint(s):_____

_____

_____

When did this symptoms or condition begin? _____/_____/_____

How did it begin: □ Gradual □ Sudden □ Intermittently or comes & goes □ Unknown

Is this complaint related to a Trauma or Injury? □ Yes □ No If so, when did trauma occur: _____

Type of trauma: □ auto accident □ work injury □ Fall □ Sports Injury □ other: _____

Have you experienced this condition before? □ Yes □ No If so, When and please explain:_____

_____

Has this condition become worse recently? □ Yes □ No

If Yes, how has is worsened: □ Gradually Worse □ Abruptly Worse □ Erratic If No, has it: □ Remained the Same □ Gotten Better

What activities aggravate your complaint(s)? _____

Is there anything, which has relieved your complaint(s)? □ Yes □ No If Yes, describe:_____

If No, please describe what you tried that did not help: _____

Type of Pain (check all that apply): □ Sharp □ Dull □ Ache □ Burn □ Throb □ Spasm □ Numb □ Tingling □ Shooting

Please rate the Level of Pain Now: 0 1 2 3 4 5 6 7 8 9 10 (if more than one area please identify)

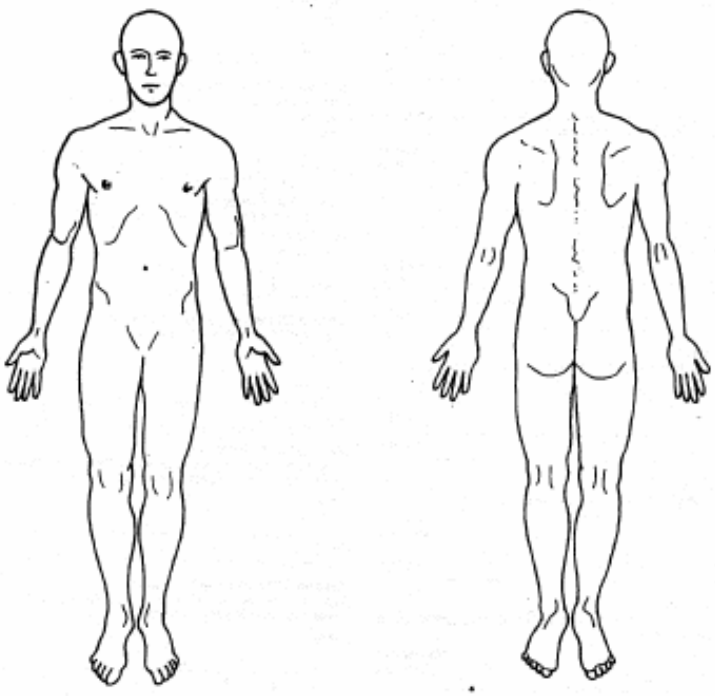
0 = no pain 10 = ER / worst pain you have ever experienced

Does the Pain Radiate or Travel into your: □ Head or Face □ Arm □ Leg □ Does not radiate or travel

Please tell us where your pain is today, and describe it in each area.

1. Dull & Ache
2. Sharp
3. Stabbing
4. Burning
5. Throbbing
6. Spasm
7. Numbness
8. Tingling
9. Radiating
10. Shooting

Circle the area of Pain and Number each area.



Describe each area identified

Area Number Type of Pain (use number from above)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Name: _____ Date: _____

## PURPOSE OF THIS VISIT continued

How often does your complaint(s) affect you? □ Daily □ 4-6X's/Week □ 2-3X's/Week □ 1X/Week □ other: _____

How often do you experience these symptoms throughout the day? □ 100% □ 75% □ 50% □ 25% □ 10% □ Only with Activity

Does complaint(s) interfere with: □ Work □ Sleep □ Hobbies □ Daily Routine Explain: _____

_____

Are your symptoms Worse: □ in the morning □ in the afternoon □ in the evening □ No change through-out day □ other:_____

Are your symptoms Better: □ in the morning □ in the afternoon □ in the evening □ No change through-out day □ other:_____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Have you had any changes in bodily functions since the condition began? □ Yes □ No

| | | | | | |
|---|---|---|---|---|---|
| □ Balance | □ Bowl Habits | □ Breathing | □ Vision | □ Weakness | □ Grip Strengh |
| □ Coordination | □ Urination | □ Coughing | □ Hearing | □ Fatigue | □ Weight Loss |
| □ Gait | □ Menstrual | □ Sneezing | □ Sexual Function | □ Temperature | □ Weight Gain |

Are you currently under medical care for this complaint(s) or any other health condition? □ Yes □ No If Yes, please explain: _____

_____

Are You Now or Could You be Pregnant? □ Yes □ No

Do you have a pacemaker or any other surgically implanted devices? □ Yes □ No

Do you have any other Complaints or concerns with your health? _____

_____

_____

_____

Office Use Only: Doctor's notes

_____

_____

_____

_____

## EXPERIENCE WITH CHIROPRACTIC

Have you ever received Chiropractic care before? □ Yes □ No If yes, with whom? _____

Date of last visit _____ For how long were you receiving care? _____

How frequent were your visits _____Reason for visits: _____

How did you respond? _____ Reason for ending care:_____

Were you pleased with his/her service? □ Yes □ No Did your previous chiropractor take before and after x-rays? □ Yes □ No

Are you aware that posture is an important determinant of one's overall health and conveys valuable health information? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No

Explain: _____

Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? □ Yes □ No

# CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Date: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even mild forms of this posture can cause many adverse affects on your overall health.

## HEALTH LIFESTYLE

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health in general now?

- ☐ Much better now than one year ago
- ☐ Somewhat better now than one year ago
- ☐ About the same
- ☐ Somewhat worse than one year ago
- ☐ Much worse than one year ago

Where do you consider your health? ☐ Highest Priority ☐ High Priority ☐ Average Priority ☐ Low Priority ☐ Haven't thought about it.

Do you consciously exercise, eat nutritious meals, minimize stress and do things to maintain good health or improve your health? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? ☐ Walking ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ other: _____

What is your current Height and Weight? Ht: _____ Wt: _____ lbs

Do you smoke? ☐ Yes ☐ No How much? ☐ 1-5 cig/day ☐ 6-10 cig/day ☐ 1 pack/day ☐ > 1 pack/day: _____

Do you drink alcohol? ☐ Yes ☐ No How much / week? _____

Do you drink coffee/caffeinated drinks? ☐ Yes ☐ No How many cups / day? _____

Do you currently have a Drug or Substance Abuse problem? ☐ Yes ☐ No If yes, discuss with doctor.

Do you currently take any prescription or non-prescription drugs or supplements (i.e. vitamins, minerals, herbs)?

| Name | Reason for taking | Name | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## FAMILY HISTORY

Does anyone in your immediate family have any current or past health problems? Place and X in the box if YES / Applies

| Condition | Mother | Father | Grandparents Mother / Father | | Siblings |
|---|---|---|---|---|---|
| Status of Family – Living | | | | | |
| 1. High Blood Pressure | | | | | |
| 2. Cardiovasculare Disease | | | | | |
| 3. Diabetes | | | | | |
| 4. Arthritis | | | | | |
| 5. Cancer | | | | | |
| 6. Stroke | | | | | |
| 7. Back or Neck Pain | | | | | |
| 8. Other: | | | | | |
| 9. Other: | | | | | |

Office Use Only: Doctor's notes

# CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Date: _____

**REVIEW OF SYSTEMS**

1. Do you have skin, hair or nail problems? □ Yes □ No _____
2. Do you have mouth and/or throat problems? □ Yes □ No _____
3. Do you have nose and/or sinus problems? □ Yes □ No _____
4. Do you have ear problems? □ Yes □ No _____
5. Do you have eye problems? □ Yes □ No _____
6. Do you have chest or lung (breathing) problems? □ Yes □ No _____
7. Do you have heart and/or blood vessel problems? □ Yes □ No _____
8. Do you have blood or lymph node problems? □ Yes □ No _____
9. Do you have digestive problems? □ Yes □ No _____
10. Do you have genital problems (e.g. prostate, testicular, vaginal, uterus)? □ Yes □ No _____
11. Do you have Urinary (including kidney or bladder) problems? □ Yes □ No _____
12. **Females:** have you menstrual problems? □ Yes □ No _____

    Have you ever taken birth control pills? □ Yes □ No Currently taking? □ Yes □ No How long : _____ yrs

    Is there any chance that you are currently pregnant? □ Yes □ No

    Do you have an breast problems? □ Yes □ No _____
13. Do you have any nervous system diseases and/or mental health problems? □ Yes □ No _____

    _____
14. Do you have any gland and/or hormone problems? □ Yes □ No _____
15. Do you have any allergy or immunity problems? □ Yes □ No _____
16. Do you have any muscle, tendon or ligament problems? □ Yes □ No _____
17. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? □ Yes □ No _____

    _____

**PAST MEDICAL HISTORY**

18. List any diseases that you have had in the past, including childhood diseases: _____

    _____
19. Have you ever been diagnosed with or told by another medical doctor that you have a particular condition, such as diabetes, cancer, AIDS, cardiovacular disease, etc.: _____

    _____
20. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head trauma, lacerations, sprains, strains, dislocations, broken or cracked bones? □ Yes □ No Please describe: _____

    _____

    _____
21. List any surgeries or operations you have had (don't forget appendix, tonsils, ear tubes, vasectomy, hysterectomy):

    1. _____ date:_____
    2. _____ date:_____
    3. _____ date:_____
    4. _____ date:_____
    5. _____ date:_____
    6. _____ date:_____

| Office Use Only: | Doctor's notes |
|---|---|
| | |

# CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Date: _____

## HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma, stress, unbalanced muscles and the affect of gravity on our bodies. When our spine becomes misaligned and unbalanced from its normal position, this will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Posture (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please check any health condition you may be experiencing now and/or in the past.
Indicate "C" for current condition, "P" for past condition, or you may check both.

### CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

| | | |
|---|---|---|
| □ C □ P Neck Pain | □ C □ P Eye Redness or Discharge | □ C □ P Loss of smell |
| □ C □ P Neck Stiffness | □ C □ P Dry eyes | □ C □ P Allergies/Hay fever |
| □ C □ P Neck Lump or Mass | □ C □ P Dizziness | □ C □ P Nasal Discharge |
| □ C □ P Headaches: Stress | □ C □ P Loss of Balance | □ C □ P Recurrent colds/Flu |
| □ C □ P Headaches: Migraine | □ C □ P Spinning sensation or Vertigo | □ C □ P Low Energy/Fatigue |
| □ C □ P Pain into your shoulders/arms/hands | □ C □ P Ear Pain | □ C □ P TMJ/Pain/Clicking |
| □ C □ P Numbness/tingling in arms/hands | □ C □ P Ringing in Ears | □ C □ P Bad Breath |
| □ C □ P Weakness in grip | □ C □ P Hearing loss or disturbance | □ C □ P Loss of taste |
| □ C □ P Coldness in hands | □ C □ P Ear discharge | □ C □ P Loss of touch sensation |
| □ C □ P Eye pain | □ C □ P Thyroid conditions | □ C □ P Stroke or TIA |
| □ C □ P Visual disturbances | □ C □ P Sinusitis | |

### THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

| | | |
|---|---|---|
| □ C □ P Chest Pain | □ C □ P Fatigue | □ C □ P Shortness Of Breath |
| □ C □ P Heart Palpitations | □ C □ P Swelling in the legs | □ C □ P Pain On Deep Inspiration/Expiration |
| □ C □ P Heart Murmurs | □ C □ P Changes in skin color | □ C □ P Frequent/chronic cough |
| □ C □ P Tachycardia | □ C □ P Heart valve problems | □ C □ P Phlegm/expectorant |
| □ C □ P Heart Attacks/Angina | □ C □ P Recurrent Lung Infections/Bronchitis | □ C □ P Coughing up blood |
| □ C □ P Fainting | □ C □ P Asthma/Wheezing | □ C □ P Blue skin (cyanosis) |

### THORACIC SPINE (MID BACK):

Postural distortions from subluxations in the mid back will weaken the nerves into your ribs/chest, urinary and upper digestive tract, and affect these parts of your body. Do you experience…?

| | | |
|---|---|---|
| □ C □ P Mid Back Pain | □ C □ P Reflux | □ C □ P Bloating, Abdominal distention |
| □ C □ P Pain Into Your Ribs/Chest | □ C □ P Nausea | □ C □ P Hypoglycemia |
| □ C □ P Abdominal Pain | □ C □ P Ulcers/Gastritis | □ C □ P Tired/Irritable after eating or when you haven't eaten for a while |
| □ C □ P Indigestion/Heartburn | □ C □ P Cramping | |

### LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet, lower digestive tract, urinary and pelvic organs and affect these parts of your body. Do you experience…?

| | | |
|---|---|---|
| □ C □ P Low back pain | □ C □ P Constipation | □ C □ P Change in Urine Color |
| □ C □ P Pain into your hips/legs/feet | □ C □ P Diarrhea | □ C □ P Kidney Stones |
| □ C □ P Numbness/tingling in your legs/feet | □ C □ P Pain during Urination | □ C □ P Menstrual irregularities/cramping (females) |
| □ C □ P Coldness in your legs/feet | □ C □ P Recurrent bladder infections | |
| □ C □ P Muscle cramps in your legs/feet | □ C □ P Change in Frequency of urination | □ C □ P Sexual dysfunction |
| □ C □ P Weakness/injuries in your hips/knees/ankles | □ C □ P Change in Urine Flow | □ C □ P Genital Itching |
| | | □ C □ P Rectal Bleeding |

Office Use Only:
Doctor's Notes: _____

_____

_____

_____

Patient Name:_____ Date: _____

# HIPAA NOTICE of PRIVACY PRACTICES

## FRENCH CITY CHIROPRACTIC, 228 Upper River Road, Gallipolis, OH 45631

### Notice of Privacy Practices for Protected Health Information

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

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

**Uses and Disclosures**

Her are some examples of how we might have to use or disclose your health care information:

1) Your Doctor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your Doctor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4) Your chiropractor and members of the practice staff my need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to your. 164.520 (b)(1)(iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or use other health related information at any time.

Our Privacy Pledge

We have always and will always respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses And Disclosures Without Your Consent Or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, our revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.164.508*b)*5)(i)
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company my have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at the address above.

Initial: _____

## Your Right To Limit Uses Or Disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

## Your Right To Receive Confidential Communication Regarding Your Health Information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

**Your Right To Inspect And Copy Your Health Information**

You have the right to inspect and/or copy your health information for six years from the date that the record was created or as long as the information remains in our files.

**Your Right To Amend Your Health Information**

You have the right to request that we amend your health information for six years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

**Your Right To Receive An Accounting Of The Disclosures We Have Made Of Your Records**

It is required that we furnish you, upon your request, a copy of any information related in any way to you, which we have transmitted, to any company, or any public or private agency, or any person. You may be charged reasonable copying charges for this service which are set forth in the statues as well as a handling charge and actual postage. We may deny access to a record if we reasonably conclude that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonably be expected to endanger the life or safety of any other person.

**Your Right To Obtain A Paper Copy Of This Notice**

If you have agreed to receive privacy notices by e-mail, you may request a paper coy of this notice at any time.

**Our Duties**

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

**Re-Disclosure**

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

**Your Right To Complain**

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and we will not take any action against you if you file a complaint. You may make an oral or written complaint at any time with our practice manager or directly to the Secretary of Health and Human Services.

**Uses or Disclosures Not Covered**

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

**To contact us**

If you would like further information about our privacy policies and practices please contact at the address or phone listed above.

Effective Date: 11/01/2008. This notice will expire seven years after the date upon which the record was created.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print name: _____

Signature: _____ Date: _____