Rickert Chiropractic & Acupuncture, P.C.

Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone_____ **Cell Phone # and Provider** _____

***Home email** _____ ***Work Email**_____

Preferred Contact Method *(check one)*

❑ Primary Phone ❑ Work Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer_____ **Work #**_____

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Spouse Name_____ **Spouse Employer**_____

Emergency Contact_____ **Phone #**_____

Referred By_____

Race *(check one)* ❑ White ❑ Black/African American ❑ Hispanic ❑Other_____

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ Other_____ ❑ I choose not to specify

Verification Question *(choose only one question by checking the question, then give the answer to that question – **minimum 6 characters**)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

*email may be used to provide you a clinical summary of your visit(s) and any health information that you may request

Continued.....

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including dosage if known.
If there are no current medications, check here: ❑

1) _____ **4)** _____

2) _____ **5)** _____

3) _____ **6)** _____

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **2)** _____

Briefly list your main health problems and reason for today's visit: _____

_____

Has any doctor diagnosed you with High Blood Pressure/Hypertension presently? ❑ Yes ❑ No If yes, describe: _

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

Date of test: _____ ***Results:*** _____

Family Medical History ***(Record ONE diagnosis in your family history and the affected relative)***				
Diagnosis: (Diabetes, stroke, heart disease, cancer, MS, etc.)	Father	Mother	Sibling: (brother/sister)	Offspring: (son/daughter)
i.e. diabetes	*father*			

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑No
Have you had an X-ray or CT scan or MRI other than low back? If yes, please specify_____

Have you had previous Chiropractic care? _____

Primary Physician_____ **Phone #**_____

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

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____/_____

NAME_____ ADMIT DATE _____ (MONTH DAY YEAR)

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PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

PATIENT HEALTH QUESTIONNAIRE

1. Present Complaint:_____

_____

2. Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS): ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant, (76–100%) ☐ Frequent (51–75%) ☐ Occasional (26–50%) ☐ Intermittent (25% or less).

4. How bad is your pain or ache? Please circle a number: 0 (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

5. Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. When did your problem begin: SPECIFIC DATE IF POSSIBLE? _____

7. Did your problem begin: ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time

8. Describe how your problem began: _____

_____

9. What treatment have you received for this present condition? ☐ Surgery ☐ Spinal injections ☐ Therapy from a PT ☐ A back support ☐ Other _____ If none check here ☐

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No. If yes by: ☐ Chiropractor ☐ MD ☐ Therapist ☐ Other _____ (SPECIFY DATES & TYPE OF TREATMENT WITH RESULTS) _____

_____

11. What makes your problem better? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

12. What makes your problem worse? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

13. How would you grade your general stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

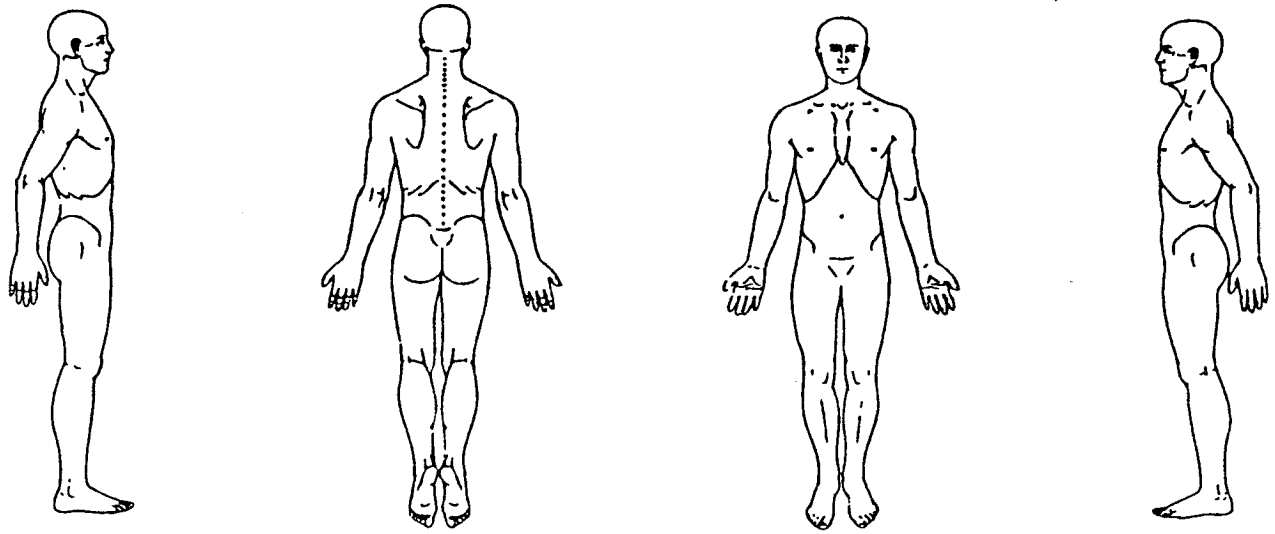
14. Physical activity at work: ☐ Sedentary More Than 50% of Workday ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise Program ☐ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?

☐ No effect
☐ Some physical restrictions (able to perform light duty work and houshold tasks).
☐ Need limited assistance with common everyday tasks.
☐ Need assistance often.
☐ Have a significant inability to function without assistance.
☐ Am totally disabled (impaired). Cannot care for self.

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient's Signature:_____ Date:_____

NAME	DATE OF BIRTH	HEIGHT	WEIGHT	SEX	DATE

Please check the appropriate box for any of the following symptoms which you **now have or have had** previously.
We want all the facts about your health before we accept you case.

THIS IS A CONFIDENTIAL HEALTH REPORT

General

Y N

- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

Muscle & Joint

- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot Trouble
- ☐ ☐ Low Back Pain
- ☐ ☐ Neck Pain or Stiffness
- ☐ ☐ Pain Between Shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen Joints
- ☐ ☐ Pain, Numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knee
- ☐ ☐ Feet

Have You Ever:

- ☐ ☐ Been Knocked Unconscious
- ☐ ☐ Used Crutches, or Other Support
- ☐ ☐ Been Treated for Spine Problems?
- ☐ ☐ Been Treated for Nerve Disorder?
- ☐ ☐ Had a Fractured Bone?
- ☐ ☐ Been Hospitalized Other Then Surgery?
- ☐ ☐ Had Surgery? (list below)*

Gastro-Intestinal

Y N

- ☐ ☐ Colon Trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult Digestion
- ☐ ☐ Distension of Abdomen
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver Trouble
- ☐ ☐ Pain Over Stomach

Eye, Ears, Nose & Throat

- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear Discharge
- ☐ ☐ Ear Noises
- ☐ ☐ Eye Pain
- ☐ ☐ Nasal Obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus Infection

Cardio-Vascular

- ☐ ☐ Hardening of Arteries
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Pain Over Heart
- ☐ ☐ Poor Circulation
- ☐ ☐ Rapid Heart Beat
- ☐ ☐ Slow Heart Beat
- ☐ ☐ Swelling of Ankles

Respiratory

Y N

- ☐ ☐ Chest Pain
- ☐ ☐ Chronic Cough
- ☐ ☐ Difficult Breathing
- ☐ ☐ Spitting up Blood
- ☐ ☐ Spitting up Phlegm
- ☐ ☐ Wheezing

Skin

- ☐ ☐ Bruise Easily
- ☐ ☐ Dryness
- ☐ ☐ Skin Eruptions (Rash)
- ☐ ☐ Varicose Veins

Genito-Urinary

- ☐ ☐ Bed-Wetting
- ☐ ☐ Blood in Urine
- ☐ ☐ Frequent Urination
- ☐ ☐ Inability to Control Kidneys
- ☐ ☐ Kidney Infection or Stones
- ☐ ☐ Painful Urination
- ☐ ☐ Prostate Trouble
- ☐ ☐ Pus in Urine

For Women Only

- ☐ ☐ Congested Breasts
- ☐ ☐ Cramps or Backache
- ☐ ☐ Excessive Menstrual Flow
- ☐ ☐ Hot Flashes
- ☐ ☐ Irregular Cycle
- ☐ ☐ Lumps in Breast
- ☐ ☐ Menopausal Symptoms
- ☐ ☐ Painful Menstruation
- ☐ ☐ Vaginal Discharge

Pregnant ☐Yes ☐No
Date of Last Period_____
Previous Miscarriages ☐Yes ☐No

Date of Last: Approx.

_____Physical Exam
_____Blood Test
_____Chest x-ray
_____Spine x-ray
_____Dental x-ray
_____Urine Test

Habits

- ☐ Alcohol
- ☐ Coffee
- ☐ Tobacco
- ☐ Drugs
- ☐ _____

*Please list any Medications now taking, Allergies and Past Surgeries:_____

_____

_____

_____

_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMEBERS

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Y N

- ☐ ☐ Alcoholism
- ☐ ☐ Cancer
- ☐ ☐ Emphysema
- ☐ ☐ Heart Disease
- ☐ ☐ Polio
- ☐ ☐ Tuberculosis

Y N

- ☐ ☐ Anemia
- ☐ ☐ Diabetes
- ☐ ☐ Goiter
- ☐ ☐ Miscarriage
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Ulcers

Y N

- ☐ ☐ Appendicitis
- ☐ ☐ Eczema
- ☐ ☐ Gout
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Stroke
- ☐ ☐ Foot Problems

After Reading and filling out the Health Questionnaire, your signature will verify that all the information you have give us is accurate and that you have read the case history questions entirely.

Signature_____Date_____

Authorizations and Releases

Name: _____ **Patient ID:** _____

Consent for Treatment

I, the undersigned, herby authorize Dr._____ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

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

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Name: _____ **Date:** _____

Notice of HIPPA Policy (Effective Date: 9/23/13)

By signing below, I acknowledge that I have received and reviewed the Rickert Chiropractic & Acupuncture, PC HIPPA notice and all of my questions have been answered to my satisfaction in language that I can understand.

Name: _____ **Date:** _____ **Signature:** _____

Signature of Legal Representative (if minor, or POA): _____

Medicare Exclusions

My provider has notified me that Medicare will deny payment for the services identified below, for the reasons stated. I agree to be personally and fully responsible for payment. **Medicare will not pay for:** Initial Examination, X-rays, Nutritional Supplements, Therapies (such as Ultrasound, E-Stim or Low Level Laser), Acupuncture or Yearly Deductibles and Co-Pays. Medicare will deny because this is not a covered charge though Medicare in a Chiropractic office.

Patient Signature: _____ **Date:** _____

Consent for Treatment of Minor

I hereby authorize Dr._____ and whomever he/she may designate as his/her assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my **(indicate relationship of child)** _____

_____ **(child's name)** _____

Guardian's Signature: _____ **Date:**_____

X-Ray/Medical Records Release

I have requested the release of records of **(Patient's Name)** _____which are a part of the records at **(Clinic)** _____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward to: **Rickert Chiropractic & Acupuncture, PC at 2323 14th Street, Columbus, Nebraska 68601**

Patient's Signature: _____ **Date:** _____

Rickert Chiropractic & Acupuncture, P.C.

Notice of Privacy Practices Effective 9/23/13

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

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Communication Barriers- If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your acknowledgement of your Privacy Notice and the Practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.
Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.
Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.
Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.
Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

DIRECTORY/SIGN-IN LOG/REFERRAL BOARD

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in the position where staff can readily see who is seeking care in the office, as well as the individual's locations within the Practice's office suite. Also in our office is a referral board, which has names of those who refer others to our office. This information may be seen by, and is accessible to, others who are seeking care of services in the Practice's offices.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:
Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.
Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.
Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so. We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.
Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work. If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.
Right to Inspect and Copy – You have the right to inspect and request copies of your information.
To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request. We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.
Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment. We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete. If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.
Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003. There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee. Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.
Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.
Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.
To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows.
Name: **Dr. Aaron Rickert, D.C.**
Address: **2323 14th St Columbus, NE 68601**
Telephone No.: **402-564-2622**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.